

MIDWIVES, NURSE PRACTITIONERS AND MEDICARE: A CASE STUDY
COMPARATIVE ANALYSIS OF MEDICARE REIMBURSEMENT EFFORTS

by

Debbie Jessup
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Committee:

_____ Dr. Elizabeth Chong, Chair
_____ Dr. P.J. Maddox, 1st Reader
_____ Dr. Lehn Benjamin, 2nd Reader
_____ Dr. Holly Kennedy, 3rd Reader
_____ Dr. Vanora Hundley, Emeritus
Dissertation Chair, 4th Reader
_____ Dr. Kathy C. Richards, Assistant Dean,
Doctoral Division and Research
Development
_____ Dr. Thomas R. Prohaska, Dean, College of
Health and Human Services

Date: _____ Fall Semester 2012
George Mason University
Fairfax, VA

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Medicare Reimbursement Efforts

A dissertation submitted in partial fulfillment of the requirements for the degree of
Doctor of Philosophy at George Mason University

by

Debbie Jessup
Masters of Science
Columbia University, 1981

Director: Elizabeth Chong, Professor
Department of Nursing

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Fairfax, VA



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DEDICATION

My PhD journey has spanned 25 years, two universities and three matriculations. It would never have begun or come to final completion without the inspiration, love and support of the nine most important people in my life. This dissertation is dedicated to those beloved individuals with my eternal gratitude...

In loving memory of my parents, Harvey and Dorothy Jessup, who taught me to cherish learning and to strive always for academic achievement. It was my father's twelve year dissertation journey during my childhood, and his remarkable academic career as I grew to adulthood, that inspired me to begin this quest over a quarter century ago. But it was my mother's constant loving support and her quiet and enduring strength that gave me the confidence and courage to continue this journey... It was always about making the two of you proud – and I pray that this final graduation lights up your corner of heaven.

In fond remembrance of my sister, Dolores, who helped to make me the person that I am today. Although she never won any titles or received any degrees of her own, my sister's simple wisdom and deep compassion for everyone in her life captivated and humbled all those lucky enough to know her. When I was growing up I always felt that my achievements needed to be for both of us, but in the end I realized that it was Dolores who lifted me up and I was truly strongest when she was on my shoulders... Walk with me in spirit this one last time, sweet sister, as I cross the stage to receive our final degree.

For my husband, Lee Raitz, who said "I do" the same year I began my first PhD attempt. For a quarter of a century he has stood by me, believed in me and encouraged me to follow my dreams, wherever they might take me. He helped me to start my midwifery career, supported me so that I could be a full-time mom, and made it possible for me to begin this PhD quest three different times. Even as he has faced the challenges of fighting Parkinson's these last few years, he has continued to unwaveringly support my efforts to achieve this final academic goal... My lifetime love, for as long as I have known you, long before we were married, you have been

the wind beneath my wings. I am only where I am today because you have stood by my side.

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Dream
The earth sounds,
Dream
Prometheus unbound.
Toil
Let not time wane,
Toil
Thy goal attain.
Dream
To fulfill a need,
Dream
And succeed.

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I began the research thinking I could do my own transcriptions, but quickly became overwhelmed with the volume of data I was collecting. My son impetuously

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TABLE OF CONTENTS

	Page
List of Tables	xiii
List of Figures	xiv
List of Abbreviations	xv
Abstract	xvii
Chapter One	1
Chapter 1: Problem Statement	2
Introduction	2
Statement of the Problem	2
Purpose	4
Research Questions	4
Significance	5
Definition of Terms	5
Theoretical Framework	6
Summary	11
Chapter 2: Review of the Literature.....	12
Introduction	12
The Policy Making Process.....	13
Political Models.....	13
The Legislative Process	17
Special Interest Politics	27
Professionalism, Health Professions and Political Advocacy	30
Nurse Midwife Professional Organization	33
Midwifery in Early History	33
European Midwifery 1400 - 1800	35
Early American Midwifery 1600 - 1900	36
The Birth of Nurse-Midwifery 1900 - 1950	38

The Professionalism of Nurse-Midwifery	44
Midwifery Today	47
Non-ACNM Midwifery	49
Nurse Practitioner Professional Organizations	52
Origins of Nurse Practitioner Practice	53
The Professionalism of Nurse Practitioners	56
Nurse Practitioners Today	61
Medicare Policy	64
Federal Reimbursement of NPs and CNMs	70
History of Medicare and Medicaid Reimbursement through 1991	70
Previous Analyses of Medicare Reimbursement Efforts	74
Health Reform	75
Summary	83
Chapter 3: Case Study Methods Overview	85
Historical Development of Case Study Research	86
The Case Study in the 21 st Century	88
A Misunderstood Method	93
Summary	95
Chapter 4: Methodology	96
Introduction	96
Design	97
Selection and Definition of Cases	98
Procedure	100
Data Collection	104
Midwife Case	104
Nurse Practitioner Case	108
Analysis	113
Strategies for Analysis	113
Analytic Techniques	115
Peer Review	118
Scientific Rigor / Trustworthiness	118
Construct Validity	119

Internal Validity.....	120
External Validity.....	120
Reliability	121
Credibility	123
Ethical Considerations.....	123
Summary	126
Chapter 5: Findings of the Midwife Case.....	127
Historical Narrative.....	127
Midwives and Payment under Federal Programs	131
Midwives and Medicare Equity.....	135
Thematic Analysis of Interviews.....	156
Policy Agenda.....	159
Politics and the Political Process	164
Midwife Relationships.....	171
Midwife Organizational Capacity	173
Midwife Political competency.....	179
Gender Issues.....	186
Peer Review Discussion	190
Summary	194
Chapter 6: Findings of the Nurse Practitioner Case.....	195
Historical Narrative	195
Nurse Practitioners and Payment under Federal Programs	199
Nurse Practitioners and Medicare Reimbursement	207
Thematic Analysis of Interview Peer Review Discussion	219
Policy Agenda.....	222
Politics and the Political Process	226
NP Relationships	229
NP Organizational Capacity	232
NP Political Competency.....	237
Gender Issues.....	241
Peer Review Discussion	244
Summary	247

Chapter 7: Comparative Analysis of Midwife and Nurse Practitioner Cases.....	248
Historical Comparison.....	249
Early Midwife and Nurse Practitioner Efforts for Federal Payment	252
The Midwife and Nurse Practitioner Cases	254
Comparison of Thematic Interview Analyses	262
Policy Agenda Issues	266
Politics and the Political Process	269
Relationships	273
Organizational Capacity	275
Political Competency.....	279
Gender Issues.....	281
Midwife and Nurse Practitioner Comparative Case Analyses	284
Process Length of Time	284
Process Outcome	289
The Role of Gender Politics	292
The Role of Economics and Special Interest Politics	297
Summary	304
Chapter 8: Discussion	305
Reflections.....	305
Nurse Practitioner Case	305
Midwife Case.....	308
Discussion	311
Limitations	318
Implications.....	320
Research Implications.....	320
Congressional Policy Implications	322
Organizational Policy Implications	324
Educational Policy Implications	327
Dissemination of Findings	329
Appendix A.....	331
Appendix B.....	333
Appendix C.....	336

Appendix D.....	338
Appendix E.....	367
References.....	387

LIST OF TABLES

Table	Page
Table 1: Midwife Case Demographics	107
Table 2: Nurse Practitioner Case Demographics	111
Table 3: Midwife Themes.....	157
Table 4: Nurse Practitioner Themes	220
Table 5: Thematic Analysis Comparison.....	263
Table 6: Role of Bryson's Feminist Political Theory in Medicare Reimbursement Efforts	293
Table 7: Role of Feldstein's Economic Interest Group Theory in Medicare Reimbursement Efforts	298

LIST OF FIGURES

Figure	Page
Figure 1: Longest Model of the Public Policymaking Process.....	16
Figure 2: The Legislative Process.....	26
Figure 3: Basic Designs for Case Studies.....	92
Figure 4: Case Study Protocol.....	103
Figure 5: Midwife Medicare Reimbursement Timeline.....	130
Figure 6: Nurse Practitioner Medicare Reimbursement Timeline.....	198
Figure 7: Comparative CNM/NP Medicare Reimbursement Timeline.....	251
Figure 8: Policy Agenda Thematic Diagram.....	268
Figure 9: Politics and the Political Process Thematic Diagram.....	271
Figure 10: Relationships Thematic Diagram.....	274
Figure 11: Organizational Capacity Thematic Diagram.....	277
Figure 12: Political Competency Thematic Diagram.....	280
Figure 13: Gender Issues Thematic Diagram.....	282
Figure 14: Case Study Design Examples for HIA Management Research Question.....	322

LIST OF ABBREVIATIONS

Accreditation Commission for Midwifery Education	ACME
Acute Care Nurse Practitioner	ACNP
Advanced Practice Registered Nurse	APRN
American Academy of Nurse Practitioners	AANP
American Academy of Pediatrics.....	AAP
American College of Nurse-Midwives.....	ACNM
American College of Nurse Practitioners	ACNP
American College of Obstetricians and Gynecologists	ACOG
American Health Insurance Plans	AHIP
American Medical Association.....	AMA
American Midwifery Certification Board	AMCB
American Nursing (Nurses)Association	ANA
American Nurses Credentialing Center.....	ANCC
Amyotrophic Lateral Sclerosis.....	ALS
Balanced Budget Act.....	BBA
Board of Directors	BOD
Catholic Maternity Institute.....	CMI
Centers for Medicare and Medicaid Services	CMS
Certified Midwife	CM
Certified Nurse-Midwife.....	CNM
Certified Professional Midwife	CPM
Civilian Health and Medical Program of the Uniformed Services.....	CHAMPUS
Clinical Nurse Specialist.....	CNS
Congressional Budget Office.....	CBO
Department of Health, Education and Welfare	DHEW
Department of Health and Human Services	DHHS
Diagnosis Related Groups.....	DRGs
Division of Accreditation	DOA
End Stage Renal Disease	ESRD
Federal Employee Health Benefits Program	FEHBP
Frontier Nursing Service.....	FNS
Government Accountability Office	GAO
Health Care Financing Administration	HCFA
Health, Education, Labor and Pensions.....	HELP
Health Insurance Portability and Accountability Act	HIPPA

Health Maintenance Organization.....	HMO
Maternity Center Association	MCA
Medical Doctor	MD
Medicare Prescription Drug, Improvement and Modernization Act	MMA
Midwifery Education Accreditation Council	MEAC
Midwives Alliance of North America.....	MANA
National Alliance of Nurse Practitioners	NANP
National Association of Certified Professional Midwives	NACPM
National Association of Gerontologic Nurse Practitioners.....	NAGNP
National Association of Neonatal Nurses	NANN
National Association of Nurse Practitioners in Reproductive Health.....	NANPRH
National Association of Nurse Practitioners in Women’s Health.....	NPWH
National Association of Pediatric Nurse Practitioners.....	NAPNAP
National Council of State Boards of Nursing	NCSBN
National League for Nursing.....	NLN
National Organization of Nurse Practitioner Faculties	NONPF
National Organization of Public Health Nurses	NOPHN
Neonatal Nurse Practitioner.....	NNP
North American Registry of Midwives	NARM
Nurse Practitioner	NP
Nurse Practitioner Associates for Continuing Education.....	NPACE
Office of Technology Assessment.....	OTA
Omnibus Budget Reconciliation Act.....	OBRA
Patient Protection and Affordable Care Act	PPACA
Physician Payment Review Commission	PPRC
Political Action Committee.....	PAC
Professional Standards Review Organization	PSRO
Prospective Payment System	PPS
Qualified Medicare Beneficiary	QMB
Resource Based Relative Value Scale.....	RBRVS
State Children’s Health Insurance Program	SCHIP
Sustainable Growth Rate.....	SGR
United States of America.....	US

ABSTRACT

Midwives, Nurse Practitioners and Medicare: A Case Study Comparative Analysis of Medicare Reimbursement Efforts

Debbie Jessup, Ph.D.

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Dissertation Director: Dr. Elizabeth Chong

The historic health reform law included a provision that granted 100% Medicare reimbursement to nurse-midwives, marking the culmination of a nineteen year effort by the American College of Nurse-Midwives to achieve Medicare equity for its members. The purpose of this study was to formulate an in depth understanding of the politics, personalities and processes that defined the midwife Medicare reimbursement effort, and to explore how and why the process differed from the six year nurse practitioner Medicare reimbursement effort that culminated in 85% payment. The study used a comparative case study design to explore how the legislative efforts of midwives and nurse practitioners were impacted by special interest politics, feminist political epistemologies, and the realities of the political process and climate. Relevant data were collected from professional archival documents, congressional bill summaries, and interviews with professional organization leaders and advocates; and were organized using the strategies of case description and theoretical comparison. Analysis followed in the qualitative

tradition of Yin (2009) and used pattern matching and cross case synthesis analytic techniques. The study established that Feldstein's economic version of the special interest group theory was sufficient to explain the differences in process and outcome between the NP and CNM efforts, and identified strengths and weaknesses in the two groups' political competency. Bryson's feminist political theory further clarified why these processes played out differently for two seemingly similar women's professional groups, one of whose care recipients were entirely women. The findings of this study will serve as a reference and resource for increasing the political competency of nurse practitioners and midwives.

CHAPTER ONE

Midwives, Nurse Practitioners and Medicare:

Case Study Comparative Analyses of Medicare Reimbursement Efforts

Debbie Jessup

April 30, 2012

CHAPTER 1: PROBLEM STATEMENT

Introduction

The history of reimbursement for midwife services in the United States of America (hereafter abbreviated to US) reflects the larger social issue of a predominantly women's profession seeking equality in recognition and payment (Garland-Thompson, 2002). It is a struggle that has played itself out in hospitals and communities across the country, in each of the fifty state legislatures, and most recently in the federal Congressional system. It was my great privilege to have been a part of that struggle: first as a member and officer in the American College of Nurse-Midwives (ACNM) advocating for passage of their Medicare reimbursement legislation, and then as a congressional staffer working with colleagues to promote and pass the bill. Those experiences were the seeds that began this research quest.

Statement of the Problem

When President Barack Obama signed the Patient Protection and Affordable Care Act (PPACA) into law on March 23rd, 2010, it was truly an historic moment in health policymaking. The 906 page Public Law 111-148 contained hundreds of policy provisions that would change the face of health care payment and practice in this country for the 21st century. One of those provisions - Subtitle B, Part 1, and Section 3114 – deleted a provision limiting Medicare reimbursement of certified

nurse-midwives to 65% of what a physician would be paid for the same service (Public Law 111-148, 2010).

Inclusion of this provision in the PPACA was the culmination of a 19 year effort by ACNM to attain equitable Medicare reimbursement for its members. It was a process that began in 1991 when the first bill to provide Medicare payment equity for certified nurse-midwives (CNMs) and nurse practitioners (NPs) was introduced during the 102nd Congress (Primary Care Health Practitioner Incentive Act, 1991). During that 19 year span between introduction of the Primary Care Health Practitioner Incentive Act of 1991 and the passage of the PPACA, the legislative paths of the midwife and the nurse practitioner efforts took very different courses. NPs were successful in achieving 85% Medicare reimbursement after only 6 years, while it took CNMs another 13 years to attain their desired Medicare reimbursement outcome. Passage of the PPACA in 2010 afforded CNMs 100% payment equity in 2010, while NPs have yet to achieve this level of Medicare reimbursement.

Over the years, political texts and journals have explored the legislative courses of widely known health policy efforts such as Medicare, the National Health Service Corps, and the failed health reform legislative effort from the Clinton administration. Political scholars will spend the next several years evaluating the events, decisions and processes involved in the passage of the PPACA. But when it comes to relatively small legislative efforts like the midwife and nurse practitioner Medicare reimbursement efforts, the health policy literature is silent. Because

efforts like these do not historically receive that level of political scrutiny, there have been no attempts to explain the differences in political process and outcome for NPs and CNMs, or to explore what implications they might present for future legislative efforts by health professional groups.

Purpose

The purpose of this study was to formulate an in depth understanding of the politics, personalities and processes that defined the midwife Medicare reimbursement effort, and to explore how and why the process differed from the nurse practitioner Medicare reimbursement effort.

Research Questions

This comparative case study analysis delineated the legislative processes of CNMs and NPs, and addressed the question:

1. Why did ACNM and the NP organizations fare so differently in their efforts to achieve payment equity?

Specifically the study investigated:

- a. Why did the process take 6 years for NPs but 19 years for the CNMs?
- b. Why were the NPs successful in achieving only 85% reimbursement while the CNM legislative endeavor resulted in 100% reimbursement?

The study further explored the potential for causal relationships through two supplementary questions:

2. What role, if any, did gender play in the CNM and NP Medicare legislative endeavors?

3. How were the efforts of CNMs and NPs to achieve equitable Medicare reimbursement impacted by special interest politics?

Significance

The political advocacy of midwives and nurse practitioners has substantially increased over the last two decades, yet for most advanced practice nurses the political process remains vague and unsettling. The significance of this study was its in-depth examination of the Medicare reimbursement legislative efforts, well known to both professions, and the causal inferences developed about why two relatively similar nursing organizations experienced such different legislative processes and outcomes. The insights gained during the case study add to the ACNM and NP professional organizations' political knowledge base of the legislative and political processes, and can subsequently be used to develop teaching models that will increase political competency of midwives and nurse practitioners.

Definition of Terms

For the purposes of this study, the term "midwife" referred to certified nurse-midwives (CNMs) and certified midwives (CMs) who have graduated from one of the US educational programs accredited by the Accreditation Commission for Midwifery Education (ACME) (formerly the ACNM Division of Accreditation); and who have been certified by the American Midwifery Certification Board, Inc. (AMCB) (formerly the ACNM Certification Council, Inc). This term did not apply to certified professional midwives, internationally trained midwives, or lay midwives, and it did not describe graduates of midwifery programs that have been accredited by any

other agency besides ACME or who hold certifications from any other body besides the AMCB.

In this study the term “nurse practitioner” referred to a registered nurse who has completed graduate level education in advanced practice nursing from an accredited program, and who has received national board certification in one of the nurse practitioner (NP) specialties.

Theoretical Framework

Most research begins with an experience or an exposure that causes the scientist to look at the world in a new way, to question some aspect of accepted thought, or to formulate a hypothesis about a specific relationship. For me, the experience began in 1998 while serving a term of office as Regional Representative to the ACNM Board of Directors. The first stand-alone midwife reimbursement bill was introduced that year, and members of the ACNM Board of Directors made several trips to Capitol Hill to lobby for the legislation. I was struck with how men dominated the halls of Congress, and how quickly Congressional staff lost interest when the discussion turned to midwives and the women they cared for. At the time I attributed this to gender politics and the feminist epistemologies that I had embraced in my college years. Twelve years later, now employed as legislative staff in the House of Representatives, I sat in the House balcony for the passage of the Patient Protection and Affordable Care Act, and watched the final resolution of the CNM Medicare provision. Six years working in Congress had taught me that besides the politics of gender, there were also issues of competing special interests, political

competency, and the politics of reelection, all of which had played a role in the process by which this bill finally become law.

Just as my understanding of the politics and processes impacting the midwife and nurse practitioner Medicare reimbursement efforts had begun with epistemological generalizations and ended with more specific premises, so must the theoretical framework for this study take into account both macro as well as more focused theories. Together these macro and micro lenses helped to focus the study towards specific questions that warranted answering.

Because my awareness of the midwife reimbursement effort first began with a macro theory, the framework for this research commenced with the feminist world view that has guided most of my adult thinking. According to Garland-Thompson (2002), feminist theory is a complex compilation of a number different theories, teachings and policies. Liberal feminism is a discussion of equality, autonomy and personal choice. Cultural feminism, on the other hand, focuses on the appreciation of differences and a favorable understanding of the feminine culture (Garland-Thompson, 2002). Whatever differences there may be among feminist writers, however, the common thread uniting their theories is a world view in which all women suffer from some sort of oppression or exploitation and an implied commitment to ending that subjugation (Maguire, 1987).

Feminist political theory challenges traditional political beliefs that separate political actions from the personal domain. Rather than just adding women into conventional political theory, feminist political theory calls for expanding

boundaries and restructuring the existing political concepts and values (Squires, 1999). While these changes may be acceptable in philosophy, Bryson argues that they threaten the privilege men enjoy because of existing gender equalities, and potentially place the entire dominant capitalistic economic system at risk (Bryson, 1992). Feminist political theory, then, framed the struggle for midwife and nurse practitioner payment equity as something larger than just the political process and offered a different way of understanding the political efforts of two predominantly women's special interest groups to achieve payment equity.

While feminist political theory offered insight into the reimbursement efforts of women's special interest groups, there are other ideologies that more closely examine the micro processes of policy development and enactment. These had to also be considered in seeking to understand why midwives and nurse practitioners fared so differently in their reimbursement quests. A number of theories seek to explain how political processes unfold, and why specific legislative outcomes prevail. This study was concerned with a political process experienced by two special interest groups seeking to impact their economic base by improving Medicare reimbursement. Thus a framework of political theory that incorporates special interest group activity and economic incentives was also critical to explain the two different processes.

Feldstein's (2006) economic version of the interest group theory offered a strong health policy framework that helped to explain the legislative processes experienced by midwives and nurse practitioners in their respective quests for

Medicare payment equity. His theory begins with the assumption that the economic theory of government is a rational approach to explaining how our political system operates. The economic theory posits that government power is used to redistribute wealth and benefits by taking them away from those who are unable or unwilling to offer support and giving them to those who offer political support. However, Feldstein also believes that political markets differ sufficiently from economic markets because the benefits and costs are not always clearly defined. He offers a hybrid theory that applies assumptions of the economic theory to special interest group politics. The economic version of the interest group theory of government assumes imperfections in the political market where voters are uninformed about specific issues and generally vote based on packaged ideologies. In this market, special interest groups are more effective than in economic markets (Feldstein, 2006).

According to Feldstein's (2006) theory, suppliers of legislative benefits (the legislators) are always motivated to some degree by the need to be reelected. They make decisions about legislative positions based on the benefits they are likely to receive in political support (in the form of votes and capital) weighed against the costs in the amount of time they will need to invest in the legislative activity (taking time away from other political priorities). There is also an incentive for lawmakers to trade votes, i.e., they vote for a special interest bill that another member is supporting in exchange for a vote for their favored bill (Feldstein, 2006).

In this theoretical scenario, organized interest groups also make decisions based on the perceived costs of organizing and providing political support versus the potential benefits of a legislative solution. Feldstein's (2006) theory holds that special interest groups representing professionals or producers have greater incentives to organize because of the potential impact on their livelihood or profits. But there is also room in this scenario for special interest groups that represent particular populations such as the elderly, individuals with specific diseases, and minorities. The success of these groups depends upon convincing lawmakers that the benefiting population is an important source of political support. The smaller the special interest group (in population or fiscal holdings), the more difficult it will be to influence legislators. For that reason when members of special interest groups share concordant interests in a particular policy issue, they form networks or coalitions to increase their political influence in that domain. (Feldstein, 2006).

The advantage of Feldstein's (2006) economic version of the interest group theory over other economic theories is that it takes into account the political competency of individual special interest groups, as well as the engagement of individual lawmakers in a particular issue. Accordingly, this theory held particular relevance in the examination of two special interest groups (midwives and nurse practitioners) in their respective quests to garner economic reimbursement equity through the legislative process.

Summary

This dissertation was a comparative case study of two advanced practice nursing groups that sought payment equity under Medicare through the political process. Three study questions guided the research which sought to explain why midwives and nurse practitioners experienced such different processes and outcomes in their quest for Medicare reimbursement. Bryson's feminist political theory (Bryson, 1992) and Feldstein's economic version of the interest group theory (Feldstein, 2006) were advanced as potential frameworks to describe the 19 year CNM effort and elucidate how and why it differed from the 6 year NP effort. The study's significance was described as its potential to increase the political competency of the two advanced practice groups.

While feminist theory and political theory may frame the legislative endeavors of the midwives and nurse practitioners, full understanding of the processes and outcomes they experienced demands a degree of familiarity with political process, professional development, and Medicare health policy. Each of these areas were developed as part of the literature review in Chapter Two.

CHAPTER 2: REVIEW OF THE LITERATURE

Introduction

Fundamental understanding of the processes involved in policy making is essential before exploring differences in legislative efforts by special interest groups. With this in mind the literature review begins with a description of macro policy models that underpin the framework for the political process, and then moves into the micro process of policy as it plays out in the federal congressional system. Special interest groups as political entities are discussed, and then the two special interest groups in this comparative case study analysis (midwives and nurse practitioners) are explored in greater detail to better understand their development as professions and their current status in the health care system. Since this study was concerned with the process of achieving equitable Medicare reimbursement, the literature review describes the Medicare program and its political history, details the history of CNM and NP federal reimbursement efforts, and gives an overview of the health reform process which led to the passage of the Patient Protection and Affordable Care Act and the CNM Medicare equity provision.

The Policy Making Process

Political Models

The policy making process can be viewed through both a macro and a micro lens. At the macro level, we seek to explain how and why societal or special interest concerns rise to a level of political action, and how that political action unfolds. At the micro level, we look more specifically at the legislative processes that lead to an issue becoming a bill, the progress of that bill through a legislative body, and the realities of what it takes for a bill to become law. Understanding of both the macro and micro level processes is fundamental to conducting a case study of the CNM/CM and NP Medicare reimbursement policy efforts.

There are multiple models to describe the policy making process. One of the best known and most frequently cited is Kingdon's Policy Streams Model (Kingdon, 1995). This model, which attempts to explain the political dynamics that result in the formation of public policy in the federal government, was strongly influenced by the earlier Garbage Can Model developed to explain organizational behavior (Cohen, March, & Olsen, 1972).

In the Policy Streams Model Kingdon identifies three streams of concern in the political process. The problem stream contains a variety of problems that need to be addressed. Their priority in the stream remains fluid, determined by various factors such as crisis events and issue visibility, and the goal of advocates is to get their preferred problem noticed by policymakers. The policy stream contains a wide variety and range of ideas that have the potential to be solutions to problems in the

problem stream. These proposals may be new, or they may linger for years until a problem arises that they can be attached. Finally the political stream occurs independently of the other two streams. Elections, personnel changes, constituent opinions, interest group activity, and shifts in ideology all play a part in defining the political climate in which policy formation occurs (Kingdon, 1995).

According to Kingdon, policy proposals become reality when there is a coupling of the streams – a joining together of a high priority agenda item from the problem stream with a solution from the policy stream, all at a time when the climate in the political stream is ripe for a change. The coupling of these streams is often referred to as a policy window. Policy windows open briefly and infrequently, but when they open they enable an issue to move from the institutional agenda (where it has received serious attention) to the decision agenda (where it is then under review for an imminent decision), resulting in substantive policy action (Kingdon, 1995).

A second model frequently employed to explain health policy processes is the Stage Sequential Model (Hanley, 2002). In this classic systems based model, the policy process is dynamic and cyclical, and involves four stages: policy agenda setting, policy formulation, policy implementation, and policy evaluation (Anderson, 1990; Anderson, Brady, Bullock, Stewart, 1984; Hanley, 2002; Ripley, 1996)

In Stage 1 a policy problem is identified and policy consumers strive for governmental attention on the issue. If successful, the problem becomes a policy issue, and potential solutions are generated. Significant problems which have

feasible solutions and adequate consumer support may move to the policy agenda being considered by public policymakers. In Stage 2 specific legislative proposals are developed to address the policy issue, and they move through the policy process until a policy decision is made and a law is passed. In Stage 3 the government entities responsible for carrying out the new law develop the necessary guidelines and regulations and then implement the program or policy. Finally, in Stage 4 the law is evaluated for process and outcome success. Since most laws passed have a time limited authorization period and will need to be re-authorized in order to continue, successful evaluation will determine whether or not the law is reauthorized and its programs / policies continue (Hanley, 2002).

The third policy model that is most often used to explain the policy making process in the health arena is Longest's Model of the Public Policymaking Process in the United States (Longest, 2010). Longest describes a cyclical process of public policy making, where decisions are made and then revisited in a circular flow of relationships. The process is an open system, and therefore can be influenced by events and circumstances that are external to the process itself. Additionally, all the components of the system are interactive and interdependent, so that each stage of the process impacts and can be impacted by the stage that precedes and follows it.

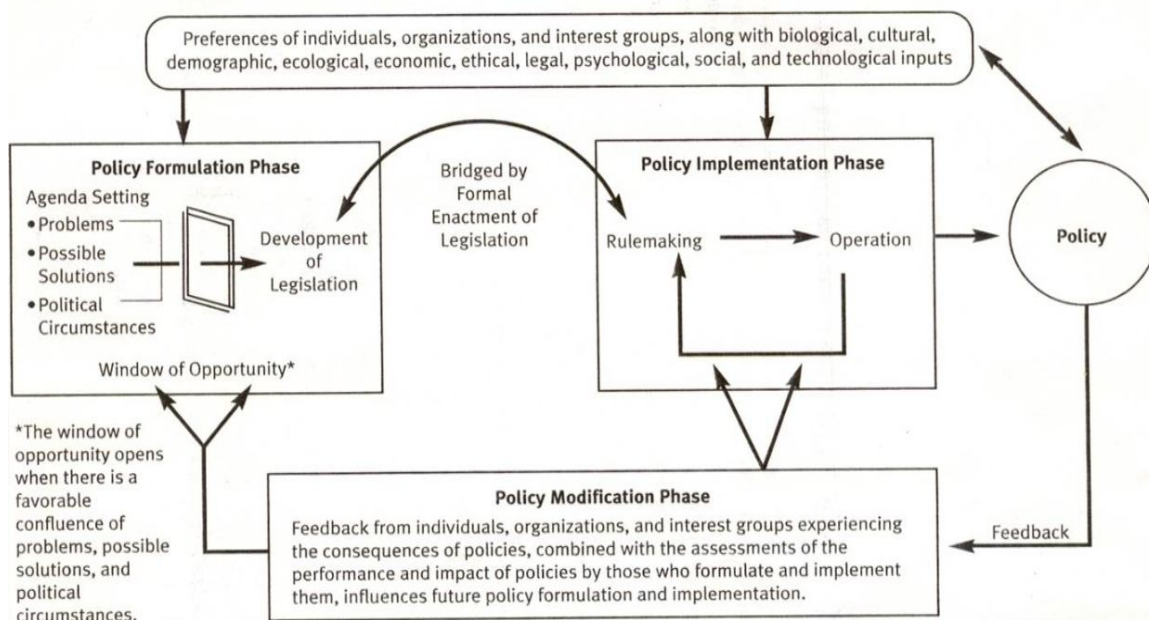


Figure 1: Longest Model of the Public Policymaking Process (Longest, 2010, p.54)

In Longest’s schematic model there are three distinct but interconnected phases. The Policy Formulation Phase encompasses a three pronged agenda setting process that reflects Kingdon’s policy streams model (problems, solutions, political considerations), as well as a legislative development process (Kingdon, 1995; Longest, 2010). Passage of the policy serves as a bridge to the Policy Implementation Phase. This second phase involves the making of rules for the passed policy, and the operationalization of the law. Finally, the Policy Modification Phase is concerned with feedback from impacted parties as well as evaluation of the policy performance and impact. The outcomes of this third phase will direct the future of this and other policy solutions (Longest, 2010)

These three macro policy process models are an important framework for understanding the political process, but a true understanding of how laws are developed and passed necessitates an understanding of the micro processes in the House of Representatives and the Senate.

The Legislative Process

Congress is a bicameral body made up of a Senate with 100 members and a House of Representatives with 435 members. Two Senators are elected from each state for a term of six years, with one third of the Senate being elected every two years. Representatives are elected for a term of two years, and each state has at least one Representative. Additional Representatives are assigned to states based on population statistics that are determined by a census and adjusted every ten years. All 435 Members of the House of Representatives are up for election every two years (Sullivan, 2007).

The legislative branch of the government is primarily concerned with legislation. Although members in both the House and the Senate may introduce legislation, the majority of laws originate in the House. The constitution mandates that all revenue bills commence in the House, and by tradition appropriations bills also begin in the House. All legislation must be approved by both the House and the Senate in order to become a law (Sullivan, 2007).

There are four forms of congressional legislative action: simple resolutions, concurrent resolutions, joint resolutions and bills. Concurrent and Simple

Resolutions are used to express a fact, purpose, principle or opinion. They are not legislative in nature and are not sent to the President for a signature. Concurrent Resolutions can originate in either the House (“H.Con.Res.”) or the Senate (“S.Con.Res.”) but are then considered by both bodies. Simple Resolutions address the rules, operation or opinion of either the House alone or the Senate alone. They are designated “H.Res.” if they originate in the House, and “S. Res.” if they come from the Senate (Dove, 1997; Sullivan, 2007).

The bill is the most common form of legislation, and may direct either public or private actions. Public actions include budget and spending bills, authorization of a program or entity, and regulatory actions. Private bills impact individuals or groups of people, and usually address immigration or naturalization issues. Joint Resolutions are similar to bills, with the exception that they may include a preamble (Resolved by the Senate and House of Representatives that...) and may be used to amend statutes or the Constitution. Bills and Joint Resolutions are numbered separately in sequence starting with the number 1, and are designated by “H.R.” or “H.J.Res.” if they originate in the House of Representatives and “S.” or “S.J.Res.” if they originate in the Senate. A companion bill is a term used to designate a bill that is introduced in one body and is similar or identical to one that has already been introduced in the other body. (Dove, 1997; Sullivan, 2007).

The legislation involved in the midwife and nurse practitioner cases were bills that authorized a change in payment under Medicare. They were introduced with several different names during a series of Congresses in either the House, or

the Senate, or both as was the case during most Congresses. For the most part the House and Senate bills were identical companion bills to the ones introduced first in the other body. Each new Congress the bills received new numbers assigned according to the timing of the introduction.

Ideas and recommendations for a bill come from a number of sources. The Constitution gives the President authority to recommend measures he deems necessary to the Congress, and he does this either in writing or by addressing a joint session of the Congress, such as during the State of the Union address. Additionally, executive communications in the form of a report from the head of an agency or department may suggest the need for some congressional action. Ideas for bills also come from private citizens and from local and state government. Individual Members of Congress or Committees of the House or Senate may introduce a bill that addresses some problem or issue of local or national concern to the Member. And finally, special interest groups may bring an issue or problem to the Member of Congress and ask that they introduce legislation to address it (Dove, 1997; Palmer, 2011a, 2011b; Sullivan, 2007). This was the case with the Medicare Equity legislation which was brought to Members of Congress by ACNM and the nurse practitioner professional groups.

There can be only one sponsor of a piece of legislation in both the House and Senate, and his or her signature must be on the document when it is introduced. Other Members may be listed as original cosponsors, meaning that they have already signed on to the bill prior to its introduction. A bill is ready for introduction

once the provisions to be included have been agreed upon, and when it has been drafted in appropriate legislative language. Although there is no requirement that legislation must be drafted by the House and Senate Offices of Legislative Counsel, most Members and Committees work closely with this non-partisan group of attorneys who have expertise in both drafting legal language and in specific subject matter. A Representative may introduce legislation at any time that the House is in session by placing the bill in a wooden box called the hopper. Senators introduce legislation either by handing it to the Clerk at the Presiding Officer's Desk, or by formally introducing it during a statement on the floor of the Senate. In both bodies, the bill is assigned a number by the Clerk, and then it is referred to the appropriate committee or committees of jurisdiction (Palmer, 2008, 2011a, 2011b, 2011c; Sullivan, 2007).

Much of the legislative work in Congress is done in the committees. Each body has its own committees and procedural rules, which are similar but not identical to the other body. There are currently 20 standing committees in the House of Representatives, and 16 in the Senate. The committees are further divided into subcommittees that have jurisdiction over specific areas within the purview of the full committee. The composition and leadership of each committee is decided on by the majority leadership of the House and Senate. The Chair of the committee then decides on the membership in its subcommittees (Schneider, 2009; Sullivan, 2007).

The Speaker of the House assigns each bill to one or several committees depending on the content matter of the bill and the committees' jurisdictions.

Generally the Speaker designates a primary committee, and may place time limits on the first or subsequent committee considerations. In the Senate the Parliamentarian makes the assignment of the bill on behalf of the Presiding Officer. Unlike the House, Senate bills are assigned to the committee which has the greatest jurisdiction over the bill content (Schneider, 2009; Sullivan, 2007). Over the course of the NP and CNM Medicare equity efforts, the Senate bills were referred to the Finance Committee, Subcommittee on Health Care. The House bills were referred to the Ways and Means Committee, Subcommittee on Health, and to the Energy and Commerce Committee, Subcommittee on Health.

There is no requirement that a committee act on a bill that has been referred to it, in fact, many bills see no action during a particular Congress, and they are introduced the following Congress to begin the process anew. Members of Congress will often use a technique known as the “Dear Colleague” to try and build support for their bill. These are letters that begin with the salutation “Dear Colleague” that discuss the reasons for and components of the bill, and then ask for cosponsorship. When a bill reaches a critical mass of cosponsors, which in the House is generally considered to be 100 bipartisan cosponsors, the committee will be more amenable to acting on the bill (Dove, 1997; Palmer, 2008, 2011c)

Committees are required to have at least regular monthly meeting days. If a committee decides to take up a bill, they will first seek input from the federal departments or agencies that would have jurisdiction over the new law. Sometimes the bill is sent to the Government Accountability Office (GAO) to report on the

desirability of the proposed law, and to the Congressional Budget Office (CBO) to define the costs of enacting the legislation. The next step would be to hold hearings on major or controversial bills, or on a problem for which several bills have been offered as solutions. Hearings are generally held in Washington, D.C., and are always open to the public. Committees invite expert witnesses to testify on the pros and cons of the legislation, or potential solutions to a prescribed problem (Schneider, 2009; Sullivan, 2007).

The next step in the legislative process is the mark-up. Subcommittees will meet to discuss a bill or group of bills, and then will vote on whether to report the bill favorably to the full committee, to amend the bill and send it on to the full committee, or to table the bill for further consideration. Each member of the subcommittee has one vote, and while Senators are allowed to vote by proxy, Representatives must be in person at the markup in order to vote. After the subcommittee reports out the bill, the full committee takes it up, and has the same three options of how to act on the bill. The full committee may fail to act on a bill reported from the subcommittee, and then the bill dies for that Congress. It may report the bill out of committee just as it is received, or it may amend the measure. There are generally more amendments offered in full committee, and if the decision is made to report out a bill with extensive amendments, the committee may decide to combine all the amendments into one and report the bill with “an amendment in the nature of a substitute”(Schneider, 2009; Sullivan, 2007).The PPACA that contained the CNM Medicare equity provision was reported out of committee in the

Senate in a drastically changed state from its House version, essentially an amendment in the nature of a substitute. Therefore although it had the same name as the House bill, it was no longer the same bill and House members were not anxious to pass it. This will be discussed further in the section on Health Reform.

When a bill is reported out of Committee it is accompanied by a written document called a report that contains the history of the bill and its changes, a section by section analysis, an estimate of the cost and impact, and a statement of the majority and sometimes minority views as to why the bill should be enacted into law. The bill is then placed on a House or Senate calendar and scheduled for floor consideration (Schneider, 2009; Sullivan, 2007).

Floor consideration of legislation differs dramatically between the Senate and the House of Representatives. The House is guided by a complicated group of rules, precedents and practices that define floor consideration. There are limitations on amendments and debate, and the majority party has complete control over the process. The Senate on the other hand emphasizes the rights of individual Senators, and there are neither limitations on debate nor rules that disadvantage minority members. This allows for filibusters that are only breakable by invoking cloture, a vote to end the filibuster debate. The cloture vote requires three fifths of the Senate to approve and can't be voted on until two days after it is proposed. This makes the magic number for passing controversial legislation in the Senate 60 members. The Senate can function more efficiently only when its members unanimously agree to

function outside of standing rules, and this happens only rarely and on non-controversial legislation (Davis, 2010; Heitshusen, 2010).

Each bill that comes to the House floor is governed by a rule that allows a specific time for debate and a specific number of amendments. The amending process on the Senate floor is quite different. Debate continues until every Senator has offered every amendment they wish to offer, and those have all been voted on. Regardless of their differences, when the debate and amending process in each chamber is complete, Members in the House and Senate vote on final passage of the bill (Davis, 2010; Heitshusen, 2010).

Differences between House and Senate passed bills are managed in one of two ways. The first is by a process called concurrence. Whichever chamber the bill originates in can pass the bill and then send it to the other body for consideration. If the second body amends the bill, it returns to the original chamber for another vote. Passage of the amended bill in the original chamber is called “concurrence with the House/Senate amendments and the amended and concurred bill is then sent to the President for signature. The other process involves a conference between the two chambers. When one chamber has amended a bill passed by the other body, either chamber can request a conference. If both chambers agree to a conference, they each appoint conferees who will vote as a unit. The conferees will discuss and make compromises to recede to the amendments of one or the other body. Then they will vote on those amendments that are in disagreement, and a report will be created from the conference. The conference report must then be voted and passed by both

chambers in order to be sent to the President for signing into law (Dove, 1997; Sullivan, 2007).

The following chart from depicts the process by which bills become law.

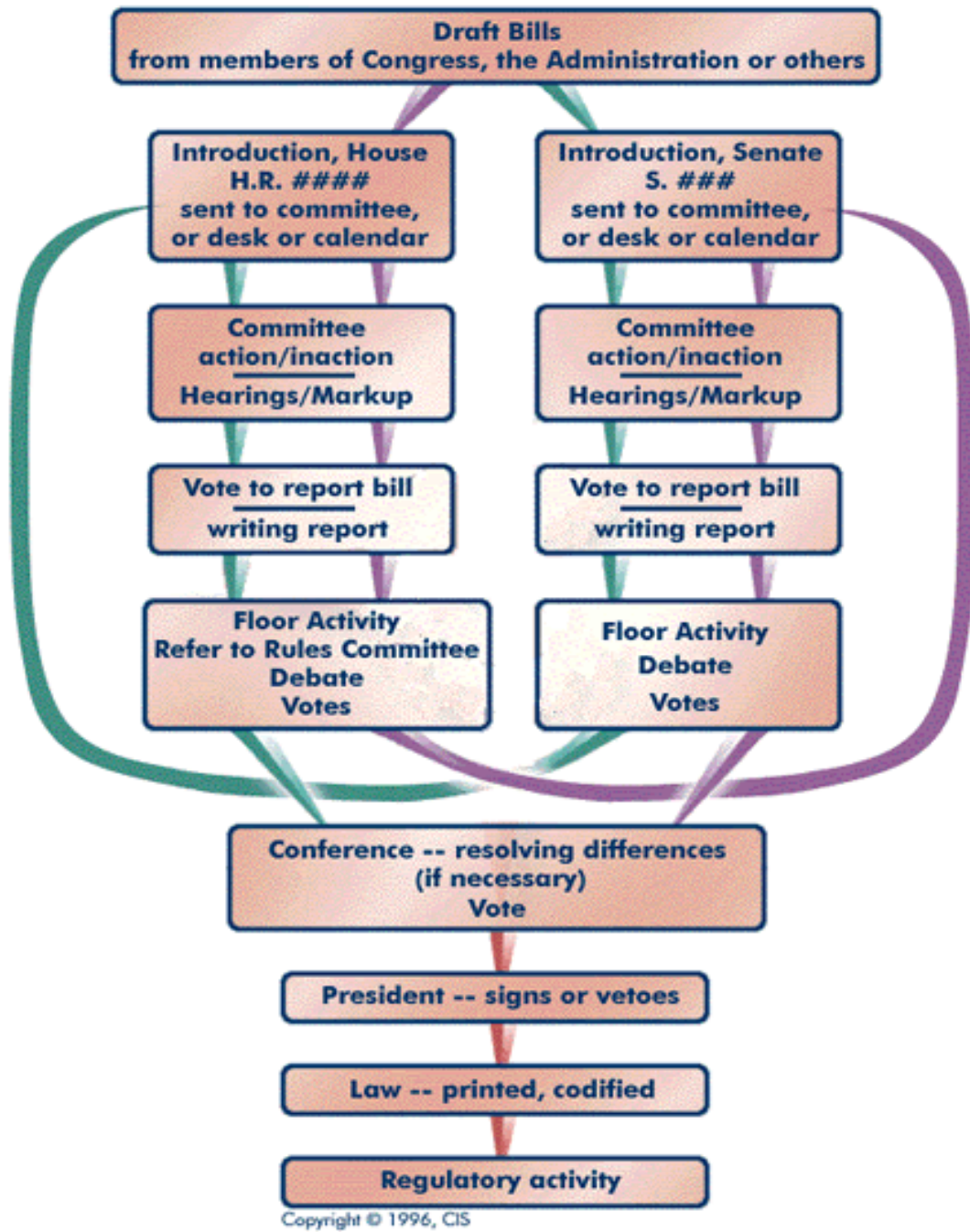


Figure 2: The Legislative Process
LexisNexis, 2007

Special Interest Politics

The notion of special interest groups is as old as our democracy. Longest (2010) points out that in the Federalist Papers, James Madison first offers us an early picture of how groups impact the role of a democratic government. He cites Madison's definition of factions: "a number of citizens, whether amounting to a majority or a minority of the whole, who are united and actuated by some common impulse of passion, or of interest, adverse to the rights of citizens, or to the permanent and aggregate interests of the community" (Longest, 2010, p. 38).

The First Amendment of the US Constitution grants and protects an entitlement allowing individuals to peaceably assemble and petition the government to take up their grievances and concerns. As our democracy has matured this right has evolved, and today it is realized through the existence of formalized special interest groups. Special interest groups are collections of individuals organized around some common interest or purpose, which seek to influence policy. In the political system of the 21st century, organized interest groups have become the most effective demanders of public policy (Lindblom & Woodhouse, 1993; Longest, 2010)

Special interest groups began to proliferate rapidly in the early part of the 20th century. The expansion and professionalization of the economy brought on by the industrial revolution spurred the development of many types of organizations seeking to impact federal policy, and by the 1950s iron triangle networks were a fixture in US politics. These triangles were made up of private interest groups that

were usually industry or trade associations, government agencies, and Congressional committee or subcommittee members (Malone, Chaffee, & Wachter, 2002).

The liberal social climate of the 1960s fueled the development of a new breed of special interest group. Ideological foundations sprung up around issues of civil rights, economic policy and foreign involvement, and political tactics expanded to include boycotts and protests. But the closing decades of the century saw a distinct rebound reaction marked by a proliferation of more conservative, right-wing interest groups. Significant campaign finance reforms allowed these groups to play a more dominant role in electing their chosen candidates (Malone et al., 2002).

Today there are more than 11,000 formal special interest associations at the national level, and another 16,000 state and regional organizations that seek to impact policy (*Directory of Associations*, 2009). Add to these numbers the non-profit research foundations and loosely organized special interest consumer groups and one can begin to understand the fragmented nature of our pluralist political system. Special interest groups may cater to groups or they may represent individual members. Their mission may represent the economic interests of their members, or it may follow a more ideological focus. The groups may have come together around a single agenda, or they may have developed to promote collective interests in a particular domain like women's health or minority disparities (Malone et al., 2002).

Regardless of their composition or mission, interest groups utilize four main strategies to influence the policy making process. The first and most common tactic

is lobbying, which at its essence is communication with policy makers in order to influence their decisions. Lobbying can be carried out by the membership of the organization, by its national office federal affairs staff, or by a contracted professional lobbyist. While lobbying best succeeds with an already sympathetic lawmaker, there is no doubt that the volume of lobbying on a particular issue contributes to its success. Additionally, professional lobbyists are not only politically savvy but usually are experts on the issues or groups they represent, so they can serve as sources of information and innovative ideas for lawmakers (Edwards, Wattenberg, & Lineberry, 2009; Longest, 2010).

The second strategy used to influence policy is electioneering, and this is often closely related to lobbying efforts. Electioneering refers to helping policy makers win political campaigns. It can take the form of political advocacy for a candidate, but more often than not it involves monetary contributions to political campaigns. Because there are laws regarding the use of organizational funds for political contributions, many special interest groups establish political action committees (PACs) that manage the distribution of their political donations (Edwards et al., 2009; Longest, 2010).

The third approach is much less widely used, but played a very significant role in the recent health reform law debate. Interest groups may seek litigation on behalf of their members to stimulate new policy, or to challenge an existing policy or regulation. The group may initiate a test case, or they may join in an ongoing litigation by submitting an “amicus curiae” or “friend of the court” brief in support

or opposition to the case (Edwards et al., 2009; Longest, 2010). In the recent Supreme Court case regarding the constitutionality of the PPACA multiple special interest groups filed amicus briefs that represented their memberships' pro or con beliefs about the health reform law.

The final tactic for influencing policy is shaping public opinion. This can be a very costly strategy, as it generally involves media time to promote an opinion. During the Clinton administration health reform effort this strategy was used with great success by a coalition of special interest groups who sponsored the Harry and Louise ads that effectively turned public opinion against health reform (Edwards et al., 2009; Longest, 2010). With the explosion of new and less expensive media this will probably become a much more widely used tool to shape policy in the future.

Professionalism, Health Professions and Political Advocacy

The federal government's role in health has grown dramatically since WWII, beginning with the Hill-Burton Act in 1946 to expand the availability of hospitals, and then solidified with the institution of Medicare and Medicaid in 1965. With this growth has come the proliferation of a variety of health related special interest groups that attempt to influence health policy. Longest classifies these groups into three main categories: primary health service providers, secondary provider organizations, and health related interest groups (Longest, 2010).

Primary health service providers include all those organizations that provide direct services to the population, including facilities, laboratory and imaging, and health professional groups. Feldstein contends that professional associations, acting

as special interest groups, seek policy that will benefit their members in one of four ways: to increase usage of their members' professional expertise; to restrain competition by other professionals who offer comparable services; to facilitate the highest possible payment for their member's services; and to minimize their member's operating expenses (Feldstein, 2006).

This dissertation looked at two health professional special interest groups that were engaged in political advocacy attempting to achieve payment equity for their members. In order to better understand the political processes that evolved for these two groups, it was important to first explore what differentiates professions in our society, and then review the development of professionalism within the two groups.

Over the last half century sociologists have studied the development of professionalism, and have attempted to define the characteristics that differentiate a profession from other occupations. Larson described cognitive, normative and evaluative features that were unique to professions. In the cognitive dimension a profession has a unique body of knowledge and skills that are used in its practice and are imparted to its students through some sort of standardized education. In the normative dimension a profession offers a service needed by society that is guided by an ethical code, and has therefore been granted the privilege of self-regulation. Finally the evaluative dimension refers to the profession's autonomy and prestige compared to other occupations (Larson, 1977; Marchione & Garland, 1997).

Hodson and Sullivan describe a three step process for development of a profession. The first phase is similar to Larson's cognitive dimension in that the profession develops a unique knowledge base and then imparts that to its students through a systematized educational process. The second step is a combination of Larson's normative and evaluative dimensions, and involves regulation of the profession by testing the knowledge of its aspiring practitioners and then offering licensure for those who meet the standards of examination. Hodson and Sullivan's third level adds a new dimension to professional development where the profession creates an organization to represent and promote it in public and political arenas (Hodson & Sullivan, 2001; Larson, 1977; Morgan, 2010).

Probably the best known medical sociologist is Eliot Freidson whose research and writings over the last quarter of the 20th century helped to demarcate the notion of professional dominance. According to Freidson, achieving autonomy is a two stage process. First the occupation must be able to demonstrate that it does reliable and valuable work. This is best facilitated through the formation of a professional association which then defines educational requisites, practice standards, a code of ethics, a method of licensure and some type of peer review. The achievement of autonomy follows the completion of these tasks, and is a legal process that assumes some occupational degree of political and economic power. In Freidson's view only one profession within a division of labor may achieve true organizational autonomy, because the scope of that autonomy extends into and

dominates other occupations within the labor cluster (Freidson, 1970; Freidson, 1989; Wolinsky, 1988; Wolinsky, 1993).

Nurse Midwife Professional Organization

The American College of Nurse-Midwives is the professional organization that represents certified nurse-midwives and certified midwives in the United States. According to its website: “With roots dating to 1929, ACNM is the oldest women's health care organization in the United States still in existence” (*ACNM 2010 Annual Report*, 2011). Today ACNM represents approximately 6500 midwives and student midwives and has 48 jurisdictional affiliates.

Midwifery in Early History

The history of midwifery and subsequently nurse-midwifery as a profession, and the development of the American College of Nurse-Midwives as a professional organization, are critical components for understanding the midwife struggle for Medicare payment equity.

While it is likely that midwives have been in existence since the dawn of humanity, the first recorded references to midwives occur in the Genesis and Exodus books of the Pentateuch. Over the next millennium midwives are referenced in medical writings of the Greek and Roman physicians, and it appears that midwives not only attended the majority of normal births, but were also responsible for the general health care of women through much of the ancient Greek and Roman civilizations and up until the Middle Ages. During these years midwifery remained

the exclusive domain of women who had personal experience in childbirth, but who were predominantly illiterate and came from the peasant or working classes. Male shamans, priests, rabbis, doctors and surgeons were excluded from birth except in cases where dangerous or unusual problems arose. (McCool & McCool, 1989; Rooks, 1997; Roush, 1979).

The first record of formal training for midwives was a program started by Hippocrates in Greece during the 5th Century BC. Several centuries later the Greek Soranus brought the specialty of gynecology and obstetrics to Rome, and began training Roman midwives in the conduct of labor and management of the newborn. During the centuries that followed there are few references to midwifery training, although it is documented that women studied nursing and midwifery in Salerno Italy during the thirteenth century (Rooks, 1997; Roush, 1979).

By the late Middle Ages medicine had developed into a profession taught in universities, which were largely controlled by the male dominated Church. Access to the universities was limited to upper class males, and medical knowledge was preserved in Latin which even literate midwives could not read. University physicians began to regulate other medical practitioners, although midwives were initially excluded because pregnancy and childbirth were not considered medical specialties (McCool & McCool, 1989; Rooks, 1997; Roush, 1979)

European Midwifery 1400 - 1800

The first law to regulate the practice of midwifery in Europe was written in Regensburg, Germany in 1452. The Regensburg Code defined midwifery as a profession with rights equal to other regulated craftsmen, and modified versions were subsequently adopted by other European cities (Rooks, 1997; Scheuermann, 1995). In 1560 the first known French law to regulate midwives included provisions for methods of instruction, examination by the King's court, and mandatory licensure and registration (Roush, 1979).

But cities and states were not the only authorities interested in the regulation of midwives. As the power of the Church spread across Europe, a primary concern for clergy was the loss of a soul to the devil. Since midwives were often the sole presiders at the unfortunate death of a mother or infant, the Church sought control of those final confessions and emergency baptisms. The Catholic midwifery code enacted in Frankfurt in 1573 was the first in a series of church regulations governing the practice and conduct of midwives (Scheuermann, 1995) Under the new regulations midwives had to attend bible classes, were prohibited against using any herbs or analgesia, and were forced to perform intrauterine baptisms using a syringe. Midwives who did not comply with the regulations were accused of witchcraft and frequently executed. During the most active years of the Inquisition in Germany over 60,000 people were burned at the stake. Eighty percent of those executed were women, and fifty to sixty-five percent of that number were midwives (Rooks, 1997; Scheuermann, 1995)

The Age of Enlightenment brought two major changes to medical obstetrics in Europe. The first was the invention of forceps, which made it possible for a surgeon to extricate a live baby from a woman whose stalled labor was endangering her or her infant. This new skill created strong competition between the growing numbers of obstetric physicians (known as man-midwives) who were reluctant to share this technology with traditional midwives, and hastened the growth of obstetrics as a medical specialty. Then in the late eighteenth century, new hospitals for the poor sprung up across Europe to meet the increasing demands for medical training, and prostitutes and poor women were forced into these hospitals for childbirth under threat of imprisonment (Rooks, 1997; Roush, 1979).

Early American Midwifery 1600 - 1900

This was the European backdrop by which midwifery came to America. Most of the early settlers were not from the European aristocracy. There were few physicians among them, and so women healers and midwives became the sole sources of health care during the early colonial days. One of the first records of a midwife in the colonies was Bridget Lee Fuller, who arrived on the Mayflower with her Deacon husband. Some of the early midwife colonists came well trained from Europe, while other midwives learned their craft in the colonies through folklore and apprenticeship. Added to this mix were the granny midwives who came on the slave ships with a totally different set of traditions and practices. Regardless of their

origin and training , it appears from the legacy left on tombstone epitaphs that midwifery was held in high esteem in the new world (Litoff, 1982; Rooks, 1997).

The early midwives practiced in isolation, and were compensated for their services with housing, land and food. Some communities gave midwives formal positions and monetary payment. Since the Puritan tradition did not value education for women, and because birth was considered a natural process, there was no perceived need for formal training in midwifery. In fact, except for a few isolated cases of midwives being tried for witchcraft, physicians, surgeons, apothecaries and midwives were allowed to practice in the colonies with limited supervision or formal regulations until the second half of the eighteenth century (Litoff, 1982; Rooks, 1997)

As the eighteenth century drew to a close and the young country began to heal from the wounds of its revolutionary war, American men increasingly traveled to Europe for medical studies. Four American universities offered medical training for those men that could not afford a European education. As physicians and man-midwives increased in number, more and more urban upper class women sought their care for childbirth. However, concerns with modesty and high physician fees helped to sustain the place of the midwife in poor and middle class childbirth (Litoff, 1982; McCool & McCool, 1989)

The nineteenth century brought an increased use of technology and male dominated medical practices to the US. Pregnancy and childbirth were increasingly viewed as an illness, and proponents of man-midwifery argued that women lacked

the constitution to be competent birth attendants (Litoff, 1982; McCool & McCool, 1989). In reaction to these trends, the first wave of feminist women banded together to form the Popular Health Movement which stressed personal hygiene, public education and prevention of illness. However, the effort lost momentum over the second half of the nineteenth century as the newly formed American Medical Association (AMA) began to grow in numbers and power. Medicine became professionalized, and the AMA lobbied for the passage of state licensure laws which excluded non-licensed practitioners from practicing medicine. Midwife practice, without access to formal education or parallel efforts to develop licensure, became increasingly limited to poor women and immigrants (McCool & McCool, 1989; Rooks, 1997).

The Birth of Nurse-Midwifery 1900 - 1950

At the beginning of the twentieth century approximately 50% of all US births were attended by midwives. However over the next three decades a number of social, economic and political changes led to the virtual demise of midwifery in the US. First, a rapid increase in the number of hospitals, coupled with the introduction of cars which provided more reasonable transportation to the hospital, made hospital birth more accessible (Litoff, 1982; Rooks, 1997). Second, developments in anesthesia for childbirth including the morphine/scopolamine combination know as twilight sleep made hospital birth more attractive (Rooks, 1997). Third, economic prosperity in the 1920's brought more families into the middle class where they

could afford the services of a physician, stigmatizing midwives as being lower class choices for those who could not afford a physician (Rooks, 1997). And finally, the development of the Children's Bureau in 1912 with its initial collection of statistics on childbirth brought to light the high rates of infant mortality in the US. Despite the fact that the majority of deaths were due to puerperal fever, which abounded in hospitals, male physicians were quick to point to midwives as the cause for these objectionable statistics (Litoff, 1982; Rooks, 1997). Physicians began a propaganda campaign against midwives that was embraced by popular magazines, and by 1930 the percentage of midwifery attended births had dropped to 15% (McCool & McCool, 1989).

Midwifery might have died out altogether in the US at this point were it not for the support of public health officials who saw midwifery as a way to improve the health of indigent rural women who had no access to physicians. With the encouragement of the public health community and the First Wave feminists Congress passed the Shepherd Towner Act Maternity and Infancy Protection Act of 1921, which authorized funds for states to improve maternal and infant health, including the training and regulating of midwives. In 1927 nearly eleven thousand midwives took advantage of federally subsidized training programs in fourteen states. And by 1929 the number of states providing midwifery instruction or educational supervision had increased to twenty-nine. Not surprisingly, the AMA strongly opposed the Shepherd Towner Act, and was successful in preventing its

reauthorization in 1929, causing many states to curtail their midwife training programs (Litoff, 1982; McCool & McCool, 1989; Rooks, 1997)

At the same time as the public health community was calling for federal investment in midwifery training, the Health Commissioner of New York City formed a committee to analyze maternity care in the city. Their recommendations led to the establishment of the Maternity Center Association (MCA) in 1918 with the mission of improving inner city prenatal care through neighborhood centers utilizing public health nurses. Soon the MCA began to advocate for the training of nurses as midwives, and in 1923 tried unsuccessfully to transition the Bellevue School of Midwifery to training its public health nurses as midwives (Rooks, 1997).

That same year a widowed Red Cross nurse named Mary Breckenridge went to England to complete a course in midwifery. She returned to Hyden, Kentucky in 1925 and founded the Frontier Nursing Service (FNS) to serve one of the most impoverished areas in Appalachia. Two other MCA nurses followed her to England to become midwives, and then joined her midwifery service in Kentucky. Breckenridge was articulate, well connected, and a very effective fundraiser. The genius of her early vision was that she proactively solicited a Metropolitan Life statistician to study the FNS maternal and infant outcomes. Results from the first 4000 births (1925 – 1940) showed that the midwife practice had significantly better outcomes than the surrounding Kentucky counties and also than the US as a nation. A follow up study of 1000 births, beginning with the 10,000th birth and ending with

the 11,000th birth (1952 – 1954) had similar findings. This made arguing against the safety of nurse-midwifery very difficult for physicians (Dawley, 2003; Rooks, 1997).

In 1931 the MCA opened the second nurse-midwifery practice in New York City. The Lobenstein Clinic would provide nurse-midwifery home birth services to a poor and predominantly black and immigrant urban population. The following year Mary Breckenridge sent one of her FNS midwives to New York to serve as the first nurse-midwifery educator, and the Lobenstine Midwifery School opened as the nation's first midwifery education program in 1932. When World War II interrupted the flow of nurse-midwives from Britain, FNS opened the second nurse-midwifery education program in Hyden in 1939 (Dawley, 2003; Dawley & Burst, 2005; Rooks, 1997).

The third and fourth nurse-midwifery education programs opened to educate black public health nurses in the south. The Tuskegee School of Nurse-Midwifery in Alabama trained 25 nurse-midwives between 1941 and 1946, but closed after only a few years due to problems arising from racism. The Flint-Goodridge School of Nurse-Midwifery in New Orleans was also a short lived effort, and graduated only two students between 1942 and when it closed in 1943. The fifth program was more successful. The Catholic Maternity Institute (CMI) School of Nurse-Midwifery in Santa Fe, New Mexico offered a six month nurse-midwifery certificate program, with an option to complete a subsequent Master of Science in Nursing Degree at Catholic University in Washington, DC. Most women who received care at CMI gave birth at home, but the service also opened La Casita which

served as a model for the birthing center movement of the 1970's and 1980's (Dawley, 2003; Dawley & Burst, 2005; Rooks, 1997).

From their early years at FNS, nurse-midwives understood the importance of having a professional organization. In 1929 FNS graduates formed the Kentucky State Association of Midwives, which later became the American Association of Nurse-Midwives under the leadership of Mary Breckenridge. Two major limitations of this organization prevented it from growing to represent nurse-midwives nationally. The first was that the American Association of Nurse-Midwives had an unwritten policy that excluded African American midwives. The second was that the organization did not set written standards for the profession of nurse-midwifery. Consequently, in 1944 Hattie Hemschemeyer convened a meeting at the MCA to discuss the need for a more inclusive professional organization. It was decided that the most fiscally prudent decision was to accept an offer from the National Organization of Public Health Nurses (NOPHN) to form an autonomous nurse-midwifery section within its ranks (Dawley, 2005; Dawley & Burst, 2005; Rooks, 1997).

From 1944 until 1952 the Nurse-Midwifery Section of NOPHN was concerned with establishing nurse-midwifery as a respected profession in the United States. To that end the members worked to develop a definition, philosophy, and standards for the scope of practice and education of nurse-midwives. But in 1952 the NOPHN and four other national nursing organizations decided to merge and form a restructured American Nursing Association (ANA) and the National

League for Nursing (NLN). Authority and oversight of nurse-midwifery was divided between the two organizations, with clinical practice becoming a function of ANA's Maternal Child Health Council, and education/administration being assigned to NLN's Interdivisional Council (Dawley, 2005; Rooks, 1997).

In 1954 twenty nurse-midwives met at the ANA convention in Chicago to discuss the formation of a national organization to represent nurse-midwives. They formed a Committee on Organization to explore potential scenarios for organizing, and in May 1955 voted unanimously in favor of forming an autonomous organization. The Committee then wrote articles of incorporation through the state of New Mexico, and in November 1955 the founding meeting of the American College of Nurse-Midwifery was held in Kansas City with 16 members in attendance. The group elected Hattie Hemschemeyer as President and formed committees to proceed with the work of writing definitions of practice, a philosophy, and standards for practice and education (Dawley, 2005)

In 1968 the American College of Nurse-Midwifery united with the American Association of Nurse-Midwives, a group that was still very much a Kentucky and FNS based organization. The combined organization changed its name to the American College of Nurse-Midwives (ACNM), a name it has retained to the present day (Rooks, 1997).

The Professionalism of Nurse-Midwifery

A small but passionate membership in the newly formed American College of Nurse-Midwives set about the work of establishing nurse-midwifery as a legitimate profession. In 1958 there were six nurse-midwifery programs. Three were certificate programs unaffiliated with a university that admitted Registered Nurses regardless of whether they had been trained at the diploma or bachelor's level, and granted a certificate upon graduation. Three other programs were graduate degree programs within universities, which admitted only bachelor's degree nurses and granted a master's degree upon graduation. At the first workshop on midwifery education attendees declared that midwifery programs would be best situated within universities and programs should lead to a master's degree. At the second Work Conference in 1967, the participants recommended that all programs be incorporated within a university by 1977. However, this has remained a controversial recommendation both within the organization and with outside educational experts. There were a total of seven nurse-midwifery education workshops between 1958 and 1992. In 1998 the Division of Accreditation directed that all certificate programs must either require a bachelor's degree upon entry, or grant one upon graduation. In 2009 the Board of Directors approved a position statement on mandatory degree requirements that established the graduate degree as the minimum standard for entry into practice (Burst, 2005; "Mandatory Degree Requirements for Entry into Midwifery Practice," 2009).

Participants at the 1958 Work Conference on Nurse-Midwifery Education also agreed that the College needed to work towards a process outside the NLN to accredit nurse-midwifery programs. In 1962 the College adopted standardized criteria for evaluation of nurse-midwifery programs, and by 1971 had approved the thirteen existing educational programs. In 1974 the Committee for Approval of Educational Programs became an autonomous Division of Approval, and in 1981 the US Department of Education recognized the ACNM Division of Approval as a legitimate agency to accredit nurse-midwifery programs. The Division of Approval was renamed the Division of Accreditation (DOA) in 1984. (Avery, 2005; Dawley & Burst, 2005; Rooks, 1997).

The development of standards for nurse-midwifery practice and education were specific objectives of the newly incorporated organization in 1955, but no directed effort was made to develop core competencies until the 1970's. In 1973 the ACNM Board of Directors (BOD) established a task force to study nurse-midwifery curricula which found significant differences between nurse-midwifery education programs. That finding prompted the BOD in 1976 to charge the Education Committee with defining and developing a set of core competencies that should be expected of all graduates of nurse-midwifery programs. The first "Core Competencies in Nurse-Midwifery" was approved by the College in 1978. The document has been revised four times, most recently in 2002, and is the basis for evaluation of educational programs and graduate competency assessment tools (Avery, 2005; Dawley & Burst, 2005; Rooks, 1997).

From establishment of the first program of nurse-midwifery up until 1970, verification of competence to practice was granted to graduates by their educational programs. The ACNM Testing Committee was first established in 1964/1965, and in 1966 the American College of Nurse-Midwifery approved its first “Functions, Standards, and Qualifications for the Practice of Nurse-Midwifery.” In 1971 the College established a national certification exam, and offered retroactive certification to 610 midwives. Three years later the ACNM Testing Committee became the Division of Examiners, and in 1984 the name was changed to the Division of Competency Assessment. The Division of Competency officially separated from the College in 1990 to become the autonomous ACNM Certification Council (Dawley & Burst, 2005; Fullerton, Schuiling, & Sipe, 2005).

As the organization began to mature, ACNM recognized the importance of quality assurance in achieving professional autonomy. In 1984 ACNM issued the first “Guide to Quality Assurance / Peer Review. In repeated position statements over the last 25 years ACNM “strongly recommends that practicing midwives participate in all aspects of quality management: quality assurance, peer review, and quality improvement”(Dawley & Burst, 2005; “Quality Management in Midwifery Care Position Statement,” 2005). Ethics was also a priority, and in 1991 ACNM adopted its first Code of Ethics. This continues to be an organizational priority and the Code was updated in 2004 (Dawley & Burst, 2005).

Midwifery Today

There is some discrepancy regarding the number of certified nurse-midwives in the US. According to HRSA there were 18,492 nurse-midwives in 2008. This number is not compatible with ACNM and ACMB statistics for certified nurse-midwives and certified midwives. Per a communication with the ACNM membership director, ACMB reports that in 2012 there are 11,497 CNMs and 73 CMs. The HRSA report appears more accurate when it cites 6,497 CNMs employed as midwives in the US. There are currently 5,756 CNM/CM members of ACNM (ACNM Membership Director, 2012; Health Resources and Services Administration, 2010).

HRSA reports that in 2008 only 55.5% of CNMs had a master's or doctoral degree, and were the least likely of all advanced practice registered nurses (APRNs) to have received their clinical education at the graduate level. This is consistent with the fact that ACNM has a long history of supporting midwifery education that prepares clinicians to meet the standards outlined in the core competencies for basic midwifery practice, whether that be through graduate or certificate programs. However since 2010 all programs have offered midwifery education at the graduate level. In 2012 there were 39 midwifery education programs in the US that together graduate approximately 350 students each year. While most programs are traditional two year master's degree programs, several offer a three year option where non-nurses can complete an accelerated RN program in one year and then continue on to the midwifery master's degree. Additionally five of the midwifery education programs are distance education programs. ACNM has taken the position

that the DNP will not become the entry degree for midwifery practice (American College of Nurse-Midwives, 2012, Health Resources and Services Administration, 2010, "Mandatory Degree Requirements for Entry into Midwifery Practice Position Statement," 2012).

Certified nurse-midwives have been licensed to practice in all 50 states since 1984, and have prescriptive authority in all 50 states. In 38 states and the District of Columbia CNMs are regulated by boards of nursing, but midwives are the only APRNs who are not solely regulated by nursing boards in every state. In five states CNMs are jointly regulated by boards of nursing and medicine, and in two states they are regulated just by the board of medicine. Additionally three states regulate CNMs under departments of Health, and two states have established boards of midwifery that regulate CNMs. Certified midwives are licensed in only three states: New York, New Jersey and Rhode Island, and have prescriptive authority in only New York (Avery, Germano, & Camune, 2010; Osborne, 2011).

The majority of states require all APRNs, including CNMs, to hold a second license. State regulations assign nurse-midwives with a variety of different titles including: advanced practice nurse, advanced practice nurse midwife, certified nurse-midwife and registered nurse practitioner. In New York, where CNMs, CMs, and CPMs are regulated by a board of midwifery they are called licensed midwives. Regardless of the regulatory title, nurse-midwives are allowed to sign documents and prescriptions with CNM after their name in all 50 states (Avery et al., 2010; Osborne, 2011).

Since the early 1970s there has been one certification process for CNMs and CMs, and until 1996 certificates were issued by ACNM for life. When ACMB incorporated as a separate entity the National Commission of Certifying Agencies strongly encouraged changing to time limited certificates. All new certifications after 1996 were issued for eight years and required proof of continuing competency, however midwives certified before 1996 were allowed to keep their lifetime certificate and participation in continuing competency was optional. In 2008 two states gave notice that they would no longer recognize ACMB unless all certified nurse-midwives had time limited certificates, and other professions were moving towards universal time limited certificates. Beginning in 2011 all CNMs certified before 1996 were issued time limited certificates, and all CNMs/CMs now need to renew their certification every 5 years showing proof of continuing competency (Barger, Camune, Graves, & Lamberto, 2009).

Non-ACNM Midwifery

Although the midwife case in this dissertation specifically encompasses the American College of Nurse-Midwives, and the certified nurse-midwives and certified midwives that ACNM represents, it is important to recognize that there are other midwives and midwifery organizations in the US. In order to better distinguish ACNM and its members these other professionals and groups will be discussed briefly in this literature review.

In the late 1960s and 1970s a new type of midwife emerged in response to the feminist and hippie countercultures. These women, known as lay midwives, functioned outside of the medical mainstream and without established educational standards. By the late 1970s it is estimated that there were several thousand lay midwives assisting at home births in rural, religious and urban activist communities across the country (Rooks, 1997).

At the ACNM 1981 Annual Meeting there was an open forum discussion about how to dialog with other midwives who were not ACNM members. The new President, Sister Angela Murdaugh, invited direct entry midwives from around the country to a meeting with the purpose of establishing an ongoing channel of communication. This led to the establishment of the Midwives Alliance of North America (MANA) in 1982, with an initial goal of uniting all midwives in the US, Canada and Mexico. A third of MANA's initial membership was CNMs, and the original founders hoped that the two organizations would eventually merge into one midwifery organization. However as MANA grew it became primarily focused on professionalizing lay midwifery, and towards that end began promoting the nomenclature of direct entry midwives and developing standards for practice and education (Rooks, 1997).

Paralleling the development of ACNM and nurse-midwifery, MANA helped to launch two other organizations focused on professionalizing the direct entry midwife. The North American Registry of Midwives (NARM) developed the first written exam for testing competencies of direct entry midwives in 1991, and

created a registry to list midwives who passed the exam. In 1994 NARM began the process of certifying experienced direct entry midwives, and in 1996 expanded this process to entry level midwives. Midwives who had successfully completed the process of certification earned the title Certified Professional Midwife (CPM) (Rooks, 1997).

MANA also helped form the Midwifery Education Accreditation Council (MEAC) to accredit educational programs for direct entry midwives in 1991. The first formally structured direct entry education program for midwives in the US was the Seattle School of Midwifery, established in 1978, which followed the European standard of three years post-secondary education for direct entry midwives. As other programs following different models opened in Florida, California and other states it became apparent that there needed to be a process for nationally accrediting direct entry midwifery programs. MEAC developed an accrediting process and pilot tested it between 1995 – 1996 (Rooks, 1997). In 2001 the US Department of Education formally recognized MEAC as a federally approved accrediting agency (“Midwifery Education Accreditation Council History,” 2012).

MANA has continued to be an inclusive organization, representing CNMs/CMs, CPMs, and direct entry midwives who are not certified, from the US, Canada and Mexico. However a request in 2000 from the Massachusetts legislature for a formal document outlining standards of practice specifically for certified professional midwives led to a discussion of whether the professional needs of CPMs were best served as a task force within MANA. In the end it was decided that

certified professional midwives needed an independent organization to represent them. The National Association of Certified Professional Midwives (NACPM) elected its first Board of Directors in 2002 and published Standards for Practice in 2004. The organization held its first national conference in March of 2012 (“History of the National Association of Certified Professional Midwives,” 2012).

Nurse Practitioner Professional Organizations

Unlike midwives, there is not one organization that exclusively speaks for nurse practitioners. The American Nurses Association (ANA) is the major professional organization representing the interests of nursing through its national office and state affiliates. Besides fostering standards for nursing, and representing the rights of nurses in the workplace, ANA advocates in Congress and the federal agencies on issues impacting nurses, advanced practice nurses and health care (American Nurses Association, 2012). There are also two national nurse practitioner organizations. The American Academy of Nurse Practitioners (AANP) is a full service professional organization that has served the nurse practitioner community since 1985 and currently has 32,873 individual members and 171 state and national group members. AANP offers continuing education opportunities, publishes a peer-reviewed journal, oversees certification exams in three NP specialties, and advocates on behalf of NP issues at the state and federal level (American Academy of Nurse Practitioners, 2012). The American College of Nurse Practitioners (ACNP) was founded in 1994 to ensure a strong federal and regulatory policy environment for advanced nurse practice. ACNP represents individual NPs as well as national and

state NP organizations in the policy arena as well as publishing a peer-reviewed journal and offering annual conferences in policy and clinical issues (“Early History of ACNP,” 2012). Additionally there are several specialty nurse practitioner organizations that advocate for nurse practitioner issues including the National Organization of Nurse Practitioner Faculties (NONPF), the National Association of Nurse Practitioners in Women’s Health (NPWH) (formerly the National Association of Nurse Practitioners in Reproductive Health (NANPRH)), the National Association of Gerontologic Nurse Practitioners (NAGNP), and the National Association of Pediatric Nurse Practitioners (NAPNAP).

Origins of Nurse Practitioner Practice

Current nurse practitioner practice in the United States has its roots in early US nursing and the public health nursing movement of the early 20th century. Professional nursing was a new entity in the 1800s. Prior to that time women with little formal training cared for their sick relatives and were generally from the lower classes. However Florence Nightingale’s work during the Crimean War transformed the perception of nursing to one that befit an upper class lady, and her Nightingale School of Nursing formalized the education of nurses in Western Europe. The first US school of nursing was established in 1873 at the Bellevue Hospital in New York City following the Nightingale model. By the late 1800s there were about 400 training programs awarding diplomas to nurses who trained by the apprenticeship model in hospitals. The majority of these graduates pursued employment in private

homes where all but the sickest of patients received their care, but some of them began to work in poor communities where they taught women about hygiene and nutrition (Mason, 2011).

One of these community nurses was Lillian Wald who founded the Henry Street Nurses Settlement on the lower east side of Manhattan in 1893 to address the poor health and terrible living conditions of the immigrants who lived there. The Settlement nurses taught classes and made home visits to promote health and hygiene, as well as encouraging exercise at the city's first playground started by Wald. A leading advocate for illness prevention and the establishment of the Federal Children's Bureau, Lillian Wald is given credit for coining the term "public health nursing" to describe this model of nursing the poor in their homes and communities (Abrams, 2008; Mason, 2011).

The early 20th century saw great advances in bacteriology and sanitation. The public health movement needed a practitioner to convey its messages of healthy living and disease prevention to the public. By 1914 nearly 2000 local governments and agencies were employing public health nurses, and 15 years later that number had jumped to over 4000. All public health nurses were proficient in health promotion, but illness care was an optional service, and many specialized in one age group, gender or disease (Abrams, 2008; Buhler-Wilkerson, 1985).

The stature of public health nursing began to wane in the post war years. Declining death rates from infectious diseases, a shrinking immigrant population, and the dramatic growth of hospital based medical care lessened the need for public

health nurses in home and community settings. Visiting nurse organizations filled the need for acute sick care at home, and the majority of public health nurses found employment in official health agencies (Buhler-Wilkerson, 1985).

The nurse practitioner movement was born in the wake of the public health nurse decline, and was fueled by a growing maldistribution of primary care health providers and the social unrest of the 1960's. Nursing leaders were exploring potential clinical content for a master's degree in nursing, and were looking for a way to reclaim the autonomous practice role that had been the hallmark of public health nursing. The first NP program was a demonstration project at the University of Colorado started in 1965 by a pediatrician, Dr. Henry Silver, and a nurse faculty member, Dr. Loretta Ford. The program was supported by a grant from the Commonwealth Fund, and combined a 4 month intense didactic curriculum with a 20 month practicum in a rural community based health station. The goal of the program was to prepare pediatric nurses for an expanded role in child care that would meet the health care needs of underserved communities and low income families. The success of the Colorado program led to the formation of nine other programs, with certificates given jointly by ANA and the American Academy of Pediatrics (AAP) (Ford & Silver, 1967; Marchione & Garland, 1997; Towers, 2011).

In 1969 the first Primex educational program opened at the University of Washington. Primex was an acronym for primary care extender that was coined by Madeleine Leininger, and the program focused on educating nurses to provide primary care and preventive health services. The Primex program was subsequently

replicated in 1971 at Cornell New York Hospital and the University of North Carolina at Chapel Hill (“AANP Historical Timeline,” 2012; Leininger, Little, & Carnevali, 1972; Marchione & Garland, 1997)

The Professionalism of Nurse Practitioners

Contrary to the slower growth and systematic efforts of ACNM to professionalize nurse-midwifery, the nurse practitioner profession developed rapidly and in multiple directions without a succinct definition or a centralized strategic plan. Besides the pediatric and adult primary care nurse practitioner tracks previously discussed, other primary care nurse practitioner programs opened around the country. In 1967 the Boston College School of nursing faculty decided to develop a new role that would complement their maternal child health graduate program. The first class of obstetric-gynecologic nurse practitioners graduated in 1969, and this NP specialty eventually became known as women’s health nurse practitioners (Fontenot & Hawkins, 2011). The first gerontology program began at North Texas State University in 1967. By 1970 ANA had established Standards for Gerontological Nursing Practice (Verderber, 1990).

Not all nurse practitioner programs trained nurses for primary care in ambulatory settings. In 1973 the March of Dimes sponsored a Blue Ribbon Panel to explore the potential role of advanced practice nurses in intensive perinatal care settings, and proposed a neonatal nurse clinician educational program. The following year the University of Arizona created a program following their

guidelines, but offering a neonatal nurse practitioner degree. A number of hospital based programs also began to offer the Neonatal NP certificate upon completion of a 4 to 9 month program. Another type of program that evolved in the 1970's blended the clinical nurse specialist (CNS) core classes with the primary care NP training and graduated Acute Care Nurse Practitioners. The ACNPs were employed in acute care settings such as trauma units and surgical departments, and helped to decrease the patient load for residents (Bowers, Gilliss, & Davis, 2011).

By 1973 there were more than 65 NP programs training nurses for the advanced practice role. Universities, hospitals and community agencies tailored the content of the educational programs to meet their needs, and competing definitions of nurse practitioner practice reflected the academic discipline where the training occurred, the scope of practice, the population served and the type of services provided. Many programs offered their own credentials, but there was no process for national certification. In 1974 the ANA Congress of Nursing Practice determined there was need for a standardized definition and credentialing process. ANA began to offer voluntary national certifying exams for NP specialties in the late 1970's, and other NP professional associations also began to create national certification exams ("AANP Historical Timeline," 2012; Bennett, September 20201; McGivern, 2010).

In 1997 there were 14 organizations offering NP certification. The National Council of State Boards of Nursing (NCSBN) was becoming concerned about the chaotic and asymmetric system of national certification for NPs, and began to collaborate with certifying organizations to ensure they were psychometrically

sound for state regulatory purposes. In 2002 the NONPF and AACN released a consensus publication describing entry level competencies in primary care for pediatric, adult, family, women's health and geriatric NPs. A series of APRN Consensus Conferences were held from 2004 to 2007, and a joint paper was finally released in 2008 by the APRN Joint Dialogue Group and the NCSBN Advisory Committee outlining future requirements for APRN education, certification, licensure and accreditation of programs (Bennett, September 2020; McGivern, 2010; Stanley, 2011).

Throughout their 45 year history nurse practitioners have frequently been a target of organized medical opposition that sought to limit their expansion into traditional medical practice arenas. Citing concerns over quality of care, physicians have struggled to limit the autonomy of NPs. In response NPs have been diligent in documenting their effectiveness, and the federal government has assisted in producing comparative analyses. The first national evaluation that gave legitimacy to the nurse practitioner role was the longitudinal study carried out by the US Department of Health, Education and Welfare (DHEW) in 1976 to identify the roles, functions, practice experiences and impact of federal funding on nurse practitioner practice ("AANP Historical Timeline," 2012; McGivern, 2010). In 1986 the Office of Technology Assessment conducted a policy analysis to compare NPs, PAs and CNMs with physicians in terms of quality of care. That study found that the quality of NP care was equivalent to MDs, and furthermore that NPs surpassed MDs in terms of preventive care and communication skills (Office of Technology Assessment, 1986).

A number of other studies over the next two decades confirmed the quality and effectiveness of nurse practitioner care (Brown & Grimes, 1993; Mundinger, Kane, & Hopkins, 2000)

One of the steps to professionalization is formation of an organization to represent and promote the profession. During most of the first decade of nurse practitioner practice, NPs found little support from ANA and had no professional organization to promote their issues. The first professional association to represent NPs was the National Association of Pediatric Nurse Practitioners (NAPNAP) founded in 1973. Following the 1974 Congress of Nursing Practice, ANA established the Council of Pediatric Practitioners, and the Council of Family Nurse Practitioners, which merged in 1977 to become the Council of Primary Health Care Nurse Practitioners. The California Coalition of Nurse Practitioners was also founded that year. In 1980 three new organizations were formed: the National Organization of Nurse Practitioner Faculties (NONPF), the National Association of Nurse Practitioners in Reproductive Health (NANPRH), and the Nurse Practitioner Associates for Continuing Education (NPACE). These were followed in 1981 by the New York State Coalition of Nurse Practitioners, in 1983 by the National Conference of Gerontologic Nurse Practitioners (NCGNP), and the National Association of Neonatal Nurses (NANN) in 1984. In total by 1985 there were nine professional organizations each discussing issues critical to the practice of nurse practitioners such as titling, licensure, certification, and standards of practice. These same nine organizations were strategizing separately about state and federal policy issues

including prescriptive authority, federal and private reimbursement, and state practice acts (“AANP Historical Timeline,” 2012; Sharp, 1996).

In 1985 six NP organizations convened a group of 310 nurse practitioners in Chicago to discuss forming a coalition that would represent all nurse practitioners and NP organizations. There were two outcomes of that Chicago Forum. The National Alliance of Nurse Practitioners (NANP) was formed to promote a unified NP response to marketing, communications and policy. The Alliance was not a membership organization, but rather had two representatives from each NP organization which at its apex included 13 organizations. The Forum also spawned a new membership organization that called itself the American Academy of Nurse Practitioners (AANP). The AANP began developing a national database of NPs, established a peer reviewed journal, and held its first national conference in 1989. AANP began exploring a national certification process, and in 1993 the AANP Certification Program incorporated as a separate entity (“AANP Historical Timeline,” 2012; Sharp, 1996).

The intent of the Chicago Forum had been to develop a unified representative organization that would speak for all NPs. However, the NANP was incorporated as a consensus model, and consequently was not successful in establishing agreements on policy and position statements. They met yearly for a decade, but never fulfilled the dream of a united voice for NPs. The AANP on the other hand formed during the Chicago Forum without majority endorsement of the NPs in attendance. The new organization grew steadily from a membership of 100 members at the end of 1985

to over 13,000 members by 2002, however there was a segment of the NP community that never felt represented by AANP, Furthermore, because they were based in Texas, they did not have a visible presence in the federal policy arena (“AANP Historical Timeline,” 2012; Bullough, 1985; Sharp, 2008).

In 1992 the National Organization of Nurse Practitioner Faculty convened a second forum of leaders from each state and national NP organization. The delegates at this meeting were concerned that there was not a strong voice in DC to advocate against barriers to NP practice, and to represent NP issues in the Clinton health reform deliberations. They recommended establishing a new organization that would be 100% focused on NP federal policy issues. In 1993 the National Nurse Practitioner Coalition was launched as an advocacy alliance of professional organizations with a separate category for individual memberships. The following year the name was changed to the American College of Nurse Practitioners (ACNP). ACNP contracted with a lobbying firm and began to advocate for NP recognition under Medicare (Sharp, 1996, 2008).

Nurse Practitioners Today

According to the Health Resources and Services Agency (HRSA) in 2008 there were approximately 158,348 nurse practitioners in the US. Of this number, 97,876 reported working in a position where their job title was nurse practitioner, and these NPs earned an average of \$83,000 per year. The majority (64%) of practicing NPs were providing ambulatory or primary care, and work settings included

hospitals (38.7%), ambulatory clinics (35.3%), academia (7.7%), public or community health (7.5%), home health and extended care nursing home (4.9%), and school health (4.4%)(Health Resources and Services Administration, 2010)

While early NPs were trained at the certificate level, the master's degree has increasingly been the entry level degree for NPs, and the last certificate programs were eliminated in 2007. Today the majority of NPs today have graduate degrees, with 84% reporting they have a master's degree and 3.9% have a doctoral degree. In 2009 there were 350 institutions of higher education that offered NP programs. During the last decade the doctorate of nursing practice (DNP) degree has been promulgated as a practice-focused doctoral degree. The vision is to prepare a workforce of nurse practitioners educated at the clinical doctorate level that would have increased parity in the workforce and could serve as faculty in RN and NP programs. Towards that end it has been recommended that the DNP be the entry level degree for NPs by 2015 (Bednash & LeBel, 2011; Health Resources and Services Administration, 2010; Sullivan-Marx, 2010).

Nurse practitioners are licensed in all 50 states under state boards of nursing, although in seven states NPs are regulated jointly by boards of nursing and medicine. The majority of NPs practice with a nursing license and an NP certificate. However since 1992 the NCSBN has encouraged states to license NPs separately as an RN and as an NP. Currently 14 states require these two levels of licensure. The degree of independence that is afforded to NPs varies by state and has increased each year. Currently 23 states including the District of Columbia license NPs to

practice independently without any physician supervision requirement. The remaining states require some degree of physician involvement in NP practice varying from collaboration to direct supervision. All states grant NPs prescriptive authority, but again with differing levels of physician participation (J. Johnson, Dawson, & Brassard, 2010; Mullinix & Bucholtz, 2011).

Certification involves the testing of entry level competency for safe practice. Although national certification for NPs remains a voluntary process, almost all states require it as a prerequisite for licensure or prescriptive authority. Currently six credentialing agencies offer national certification exams for NPs. The ANA American Nurses Credentialing Center (ANCC) offers certification in eight clinical areas, several of which overlap with other credentialing agencies. The AANC is the only agency to offer adult psychiatric and mental health NP, family psychiatric and mental health NP, and school NP certifications. The AANP Certification Program offers three certifications: adult NP, family NP, and gerontological NP. Four specialty organizations also offer certification: the American Association of Critical Care Nurses Certification Corporation offers Acute Care NP; the National Certification Corporation for Women's Health, Obstetric and Neonatal Nurses offers neonatal NP and women's health NP; the Pediatric Nursing Certification Board offers pediatric NP in acute and primary care; and the Oncology Nurse Certification Corporation offers oncology NP (Bednash & LeBel, 2011; J. Johnson et al., 2010).

In July the AANP and the ACNP announced their plans to consolidate organizations. The Boards of Directors of each organization passed resolutions

allowing the merger to move forward, and when consolidation is complete the new organization will be the largest professional association representing the nation's approximately 155,000 nurse practitioners ("Top nurse practitioner groups announce merger plans," 2012).

Medicare Policy

This dissertation looks at the policy efforts of nurse practitioners and certified nurse-midwives to achieve Medicare equity. As such it is important to understand the history and development of the Medicare program in US politics. The first seeds for the Medicare Program were sewn in 1943 when the Franklin Delano Roosevelt administration studied the possibility of a national health insurance. In response to this study, Senators John Dingell, Sr., Robert Wagner and James Murray introduced comprehensive health insurance legislation that would be paid for through payroll deductions. That bill saw no congressional action. A few years later, President Harry Truman sent a proposal to Congress to create a national health insurance fund that would cover physician visits, laboratory benefits, hospital stays, dental care and nursing services. This legislative effort met the same fate as the Dingell/Wagner/Murray bill, both being squelched by strong Republican opposition and the overtly obstructive efforts of the AMA (Aaron & Lambrew, 2008; Moon, 2006).

National health insurance was not on the political agenda again until 1957. Congressman Aime Forand introduced a bill with the support of the American Federation of Labor leader Nelson Cruikshank and other social insurance activists.

For the first time hearings were held on the proposal, and although it did not pass, Democrats were galvanized and the issue began to receive significant public attention. In 1959 the Republican Administration of Dwight Eisenhower released a report detailing opportunities for offering hospital insurance to Social Security beneficiaries. Within a month of taking office in 1961 President Kennedy began pushing for a comprehensive plan for seniors. Bills introduced by Congressman Cecil King and Senator Clinton Anderson failed to pass a House Ways and Means Committee that was dominated by conservative southern Democrats. A few months later President Kennedy was assassinated, leaving this part of his policy agenda unfinished (Aaron & Lambrew, 2008; Moon, 2006).

Lyndon Johnson was sworn into office on November 22, 1963, hours after Kennedy was killed. From the beginning he made it known that passing Kennedy's Medicare plan was his key priority. A little over 18 months later on July 30, 1965, President Johnson signed H.R. 6675, otherwise known as the Mills Bill, into law. This package of health benefits and social security improvements included both Medicare for the aged and Medicaid for the indigent. The Social Security Administration would oversee the Medicare Program, while the Social and Rehabilitative Services Administration administered Medicaid (Davis, 2010; "Medicare: A Timeline of Key Developments," 2011)

By the time Public Law 89-97 went into effect on July 1, 1966, 19 million seniors had signed up for the new coverage. There were two parts to the new Medicare Program. Part A, financed by payroll taxes from current workers and their

employers, covered inpatient hospital and post hospital services. All persons aged 65 and older were automatically covered after a yearly deductible of \$40. Part B was voluntary, financed by a monthly premium of \$3 from the beneficiary, and covered physician visits and other medical services (P.A. Davis, 2010; "Medicare: A Timeline of Key Developments," 2011).

In the 45 years since the enactment of Medicare, the program has undergone significant changes that fall into three basic categories: expansions of eligibility, cost containment changes, and benefit expansions. The first major modification came in 1972, when President Richard Nixon signed Public Law 92-603. The Social Security Amendments of 1972 expanded the program to include individuals under 65 years who had long term disabilities, and people suffering from End Stage Renal Disease. The amendments also established Professional Standards Review Organizations (PSROs) to oversee patient care and gave Medicare the authority to carry out demonstration projects. Medicare benefits were expanded to include speech therapy, physical therapy and chiropractic services, and the amendments encouraged the formation of Health Maintenance Organizations (HMOs)(Davis, 2010; "Medicare: A Timeline of Key Developments," 2011; Moon, 2006).

By 1975 Medicare had 24.9 million beneficiaries. The Part A deductible had risen to \$92 per year, and the monthly premium for Part B was \$6.70. Joe Califano, Secretary of the Department of Health, Education and Welfare (HEW) under the new President Jimmy Carter, created the Health Care Financing Administration (HCFA) in 1977 to administer both the Medicare and Medicaid programs. Approximately

1500 government workers moved from the Social Security Administration to the new HCFA (“Medicare: A Timeline of Key Developments,” 2011).

Medicare grew rapidly in the 1980s, and concern began to evolve about the solvency of the Part A Medicare Trust Fund. A number of pieces of legislation were passed to curtail the steady increase in program spending. The Omnibus Budget Reconciliation Act (OBRA) of 1980 established an outpatient surgery Prospective Payment System (PPS) that utilized Diagnosis Related Groups (DRGs) to reimburse these procedures. The Tax Equity and Fiscal Responsibility Act of 1982 expanded the PPS to HMO plans, and the Social Security Amendments of 1983 established an inpatient Prospective Payment System. The Deficit Reduction Act of 1984 froze physician fees and the Emergency Extension Act of 1985 froze PPS payment rates for inpatient hospital care (Davis, 2010; “Medicare: A Timeline of Key Developments,” 2011).

By 1985 there were 31.1 million beneficiaries. The Part A deductible was \$400 per year, and the premium for Part B was \$15.50 per month. In 1988 the newly Democrat controlled House and Senate passed the largest expansion of the Medicare program since its creation. The Medicare Catastrophic Coverage Act of 1988 created an outpatient prescription drug benefit, placed a cap on out of pocket expenses, and expanded skilled nursing facility benefits. Medicaid began coverage of Medicare premiums for low income Qualified Medicare Beneficiaries (QMBs) with incomes below 100% of the federal poverty level. The following year the Medicare Catastrophic Coverage Repeal Act repealed all but the QMB provision. OBRA 1990

expanded Medicare to include mammography and community mental health centers, and established standards for Medigap policies. The QMB benefit was expanded to include individuals between 100% and 120% of poverty, or Specified Low Income Medicare Beneficiaries, and states were required to cover premiums for this new group beginning in 2003 (“Medicare: A Timeline of Key Developments,” 2011).

By 1995 the Medicare population had grown to 37.6 million. The Part A deductible was \$716 per year, and the monthly premium for Part B was \$46.10. Efforts to control skyrocketing costs had thus far been modifications to payment systems. The next fiscal containment effort addressed the growing problem of fraud within the program. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 designated specific funds for a Medicare Integrity Program to actively address fraudulent payments. The Balanced Budget Act (BBA) of 1997 added five new PPS systems for rehab and skilled nursing categories, and further slowed the growth rate of provider payments by establishing a Sustainable Growth Rate (SGR) formula to calculate yearly adjustments to provider fees . BBA 1997 also established the National Advisory Commission on the Future of Medicare. This Commission spent two years studying the issues surrounding solvency, but was unable to come to a consensus recommendation for the future of the program (Davis, 2010; “Medicare: A Timeline of Key Developments,” 2011).

The result of the combined efforts to curb provider payments was a crisis in the availability of Medicare providers as the decade drew to a close. In response to

this problem, the Balanced Budget Refinement Act of 1999, the Medicare Medicaid and SCHIP (State Children’s Health Insurance Program) Benefits Improvement and Protection Act of 2000 and the Consolidated Appropriations Resolution of 2003 increased payments to providers, hospitals and Medicare Choice plans. Beneficiaries also saw an expansion of benefits. Patients with Amyotrophic Lateral Sclerosis (ALS) became eligible for Medicare benefits, joining End Stage Renal Disease (ESRD) patients and the disabled. In 2001, the Secretary of Health and Human Services under President George Bush renamed HCFA to be called the Centers for Medicare and Medicaid Services (CMS). In December of 2003 the Medicare Prescription Drug, Improvement and Modernization Act (MMA) established a new outpatient prescription drug benefit to begin in 2006. And in 2005 Medicare began covering selected preventive services including an introductory physical. That year there were 42.6 million Medicare beneficiaries, and the total Medicare spending was \$325 billion. The Part A deductible was \$912 for the year, and the Part B monthly premium was \$78.20 (“Medicare: A Timeline of Key Developments,” 2011).

Beginning in 2007, a series of year end “fixes” were enacted to prevent significant cuts to provider fees that were attached to the SGA formula. And in 2010 Congress passed the Patient Protection and Affordable Care Act which made multiple statutory changes to the Medicare Program. Benefit expansions in the PPACA included increased coverage of prevention services, and a gradual closing of the “donut hole” in the prescription drug program. Efforts at program cost containment included payment changes to the Medicare Advantage program,

reduced payments to hospitals that have a disproportionate share of uninsured patients (since these patients would presumably now have insurance coverage) and the creation of value based purchasing programs and accountable care organizations (Davis, 2010; “Medicare: A Timeline of Key Developments,” 2011).

Federal Reimbursement of NPs and CNMs

History of Medicare and Medicaid Reimbursement through 1991

When Medicare and Medicaid were first established in 1965 to provide medical care to the elderly and the indigent, non-physician or allied health providers employed in physician practices were fully reimbursed for their services when those services were provided as “incident to” a physician’s care. This provision provided 100% coverage of the non-physician provider’s services so long as the following criteria were met: (1) the provider was employed by a physician practice or clinic, (2) the physician initiated the course of treatment and subsequent visits by the MD were documented, and (3) the physician was physically present in the office or facility and provided direct supervision of the non-physician provider who was providing the services (Abood & Keepnews, 2000; Hoffman, 1994; The American College of Nurse-Midwives, 1999).

In the late 1970’s Medicare and Medicaid began to specifically distinguish payment policies for non-physician providers. The first policies were an attempt to improve access in underserved areas. The Rural Health Clinic Services Act of 1977 made freestanding rural health clinics that employed nurse practitioners, physician assistants and certified nurse-midwives eligible for coverage under Medicare and

Medicaid. This was the first time that federal payments for non-physician providers did not require employment in a physician's office. (Hoffman, 1994).

Prior to 1980, Medicaid payment of CNMs was optional and left to the determination of each state. Only two states had opted to reimburse CNMs directly, and approximately 14 other states reimbursed clinics, physicians or hospitals for the CNM services (Hackley, 1981). The Omnibus Budget Reconciliation Act (OBRA) of 1980 provided for direct coverage of services rendered by a nurse-midwife under the Medicaid program. The services were limited to the maternity cycle, and the payment rate was to be set by the state (Hoffman, 1994).

In 1987 the OBRA authorized the direct Medicare reimbursement of nurse midwife services, eliminating the "incident to" requirement for all CNMs. Medicare statute and regulations stated that reimbursement for CNM services would be limited to the maternity cycle and would be determined by a fee schedule established by the Secretary of the Department Health and Human Services (DHHS), (which had formerly been known as DHEW). OBRA 1987 did not include guidance for HHS as to how that fee schedule would be established, except to specify that payments not exceed 65% of the applicable prevailing charge for the same service when performed by a physician (Ament, 1998; Fennell, 1998; The American College of Nurse-Midwives, 1999).

ACNM objected to the definition of midwifery services that now limited scope of practice to the maternity cycle for both the Medicaid and Medicare programs, since this excluded payment for gynecological and newborn care. The College sent a

letter to the HCFA Administrator explaining that it had not been the intent of Congress to limit the scope of practice for CNMs, but in July 1988 HCFA rejected ACNM's position and officially defined Medicare coverage of CNMs to the maternity cycle. The ACNM Board of Directors established the scope of practice issue as a top priority for the College, and began to seek a legislative solution (Fennell, 1998).

While CNMs were busy advocating for changes in federal program scope of practice definitions, NPs were still fighting for direct payment under Medicare and Medicaid. The Omnibus Budget Reconciliation Act of 1989 authorized Medicaid payments for family and pediatric NPs, and Medicare payment for NPs working in skilled nursing facilities. This was the first time that NPs were specifically named as Medicare providers, although the payment was limited to one practice setting. The law further stipulated that the Medicare payment for NP services would be paid to the employer rather than directly to the NP (Abood & Keepnews, 2000).

OBRA 1989 also replaced the physician payment methodology that was based on "usual, customary and reasonable" fees, and established the Resource Based Relative Value Scale (RBRVS) that had been recommended by the Physician Payment Review Commission (PPRC). It also mandated a study of the implications of the RBRVS on non-physician providers (Aaron & Lambrew, 2008). Since the PPRC was given no funds to specifically study CNMs, ACNM began a small pilot study of CNM work time and intensity, practice overhead and educational expenses replicating the Harvard School of Public Health research that developed the relative value scale for physician services. The PPRC then requested that ACNM expand that

research. With a \$250,000 grant from the Robert Wood Johnson Foundation ACNM was able to intensify survey outreach to its membership, generating a more comprehensive evaluation of CNM RBRVS. The solicited data were then turned over to the Physician Payment Review Commission. The commission then asked for data on educational loan debt, and the results of that study showed that the average CNM loan debt was only \$4000 less than that of the average physician's debt. The PPRC continued studying CNMs and issued reports to Congress recommending a change in the CNM Medicare payment level. Despite the strong evidence in support of raising their reimbursement level, however, there was no move within Congress to alter the Medicare reimbursement of CNMs or that of any other non-physician providers (Marchese, 1990).

The 1990 Omnibus Budget Reconciliation Act was a defining legislation for NPs. The law included a provision that established direct Medicare payment for NPs who practiced in rural areas. While only a limited number of NPs were eligible for payment because of the way rural areas were defined, the law nonetheless established NPs as Medicare providers and gave them an important entrance into Medicare policy forums (Abood & Keepnews, 2000).

This was the state of CNM and NP reimbursement under Medicare and Medicaid when the Democrat led 102nd Congress opened in January of 1991. Nurse-Midwives were directly reimbursed under Medicare at 65% of the physician fee which was based on the RBRVS; and they were directly reimbursed under Medicaid with states setting the fee schedule. Under both Medicare and Medicaid they were

only eligible for payment of services within the maternity cycle. Nurse Practitioners were only directly reimbursed under Medicare if they practiced in a designated rural area, and that reimbursement was the same as “incident to” payments at 100% of the physician fee schedule. Only family and pediatric NPs were reimbursed under Medicaid, and the fee schedule was determined by individual states. CNMs and NPs began to search for a common solution to their reimbursement struggles, and that effort will be detailed in the discussion of the CNM and NP cases.

Previous Analyses of Medicare Reimbursement Efforts

There have been no qualitative or quantitative attempts to date to analyze the nineteen year legislative effort of ACNM to secure equitable Medicare reimbursement for its members. Furthermore, only one author has taken an analytical lens to the NP process of Medicare reimbursement since its resolution in 1997. That effort was qualitative in nature and was part of a PhD dissertation. The final dissertation was not retrievable for review so the summary of the research is based on the one published article from that work.

In 1999 Wong used Kingdon’s Policy Streams Model (discussed earlier in this literature review) “to analyze why U.S. legislation for direct Medicare reimbursement to advanced practice (registered) nurses was approved during the 105th congressional session” (Wong, 1999, p.167). Data were collected through telephone interviews, internet searches, and a review of documents from the

American Nurses Association. No analytic methodology was described (Wong, 1999).

Wong found that Kingdon's framework was sufficient to explain the success of the reimbursement effort during the 105th Congress. A policy problem was identified, i.e., lack of access to cost effective quality care by Medicare beneficiaries coupled with rising Medicare costs. One possible solution to this was increased use of nurse practitioners, whose quality had been well documented along with specific barriers to their usage. One of those barriers was lack of direct Medicare reimbursement to NPs, and a legislative solution had been introduced in previous congresses. Wong found that political pressure to get Medicare costs under control resulted in a vehicle (the Balanced Budget Act of 1997) that could carry the NP legislation. Additionally she found that effective lobbying by multiple nursing organizations added to the success of the effort, although fragmentation of the different groups was a problem (Wong, 1999).

Health Reform

The literature review would not be complete without some discussion of the legislative vehicle that included the CNM Medicare equity bill and enabled its passage. The Patient Protection and Affordable Care Act that was signed into law in March 2010 was the culmination of decades of political effort by both Democrats and Republicans in response to a health care system that cost twice as much as any other country but left millions without access to basic health care services.

Understanding how and why this bill came to fruition in 2010 is critical to understanding the final chapter of the CNM Medicare equity effort.

The last great health reform struggle occurred during the first two years of the Clinton presidency, in the Democrat controlled 103rd Congress. Many political scholars have evaluated the dramatic failure of that effort (Johnson & Broder, 1996; Rushefsky & Patel, 1998; Skocpol, 1996). Their findings hold no real relevance for this dissertation, with the exception of three factors that were noticeably absent in the 2009-2010 health reform quest, and therefore shed some light on why that effort might have been successful when the Clinton effort was not.

When Bill Clinton was elected President in 1992 he inherited a Democrat controlled Congress that included a significant southern conservative bloc. The divide of that 103rd Democratic Congressional Caucus made it almost impossible to come to consensus on the content of a health reform bill. As a new President, Clinton brought together a 500 member task force that spent much of his first year in the White House detailing a plan for Congress to follow. More months were spent in Congress turning that road map into a bill, and then waiting for the Congressional Budget Office to assign scores to the provisions in the bill. Meanwhile the many segments of the health care industry united in opposition to the Clinton plan and helped to shift popular sentiment against meaningful health reform and the Democrats in Congress who supported it. Before the bill ever came to a vote, the election of 1994 brought a new Republican majority to both houses of Congress, and the Clinton health reform effort was finished (Hacker, 2010; Jacobs, 2010).

Barack Obama was elected President in 2008, following a 2006 midterm election that brought a Democrat majority back to Congress. The 2008 elections significantly strengthened the Democrat hold of both chambers, and while the Caucus was far from unified, the southern conservative block had been largely replaced and the 111th Congress was at least more homogeneous than it had been during Clinton's presidency. The three major Democratic candidates for President had endorsed essentially the same health reform proposal during their candidacies, so the effort started with some degree of Democratic unity. Obama, unlike his Democrat predecessor, used his presidency to endorse the need for health reform, but left the specifics of the legislation to the Congress. And even before Obama was elected, the Democrat appointed Director of the CBO, Peter Orszag, began to build up the numbers and expertise of his agency to be able to meet the demands of evaluating health reform proposals in a timely manner (Hacker, 2010; Jacobs, 2010).

On November 12, 2008, less than two weeks after the elections foretold unified party control of the Congress and Presidency, Max Baucus, the chairman of the Senate Finance Committee, issued a white paper outlining his ideologies for health reform. The two month lame duck period before the 110th Congress came to a close saw a flurry of meetings and discussions with industry and advocacy stakeholders about health reform principles. The 111th Congress was to begin on January 3rd, 2009 and health reform would be at the top of the agenda for both chambers (Chaikind, 2010; Hacker, 2010).

In the first few weeks of the 111th Congress a number of health reform bills were introduced by individual members of Congress, including a proposal by Representative John Dingell to establish a national government provided health insurance program. Speaker of the House Nancy Pelosi directed three House committees: Energy and Commerce, Ways and Means, and Education and Labor, to develop proposals for health reform. Senate Majority Leader Harry Reid gave the same charge to the Senate Health, Education, Labor and Pensions (HELP) and Finance committees (Chaikind, 2010).

Besides party unity, Presidential delegation to Congress, and a CBO with better capacity to handle the budget evaluations, there was another significant difference in the 111th Congress that strengthened the health reform effort. During the Clinton administration it was primarily unions and public interest groups that were fighting for health reform, while industry was united against it. This time however, the economic downturn that began during the Bush administration and worsened through 2008 left many individuals jobless and without insurance and many others underinsured. Health industry leaders began to worry about declining health consumption. The American Health Insurance Plans (AHIP) realized that having more people insured because of a mandate was good for their business. The hospital and pharmaceutical industries determined that greater public regulation meant more guaranteed payments, and they got on board the health reform bandwagon. The AMA saw health reform as a way to fix the steep scheduled reductions in physician payment resulting from the flawed SGR formula. Many

segments of industry began to bargain their support for the legislation while working out concessions to protect their industries. The deals made were substantial, and as a result health reform legislation strengthened the current private system of payment and delivery rather than a radical restructuring favored by liberals. In the end, the major opposition came from business groups like the Chamber of Commerce, and AHIP strongly opposed provisions that regulated their industry (Hacker, 2010; Jacobs, 2010).

The House of Representatives was first to meet the challenge of developing and passing legislation. H.R. 3200, America's Affordable Health Choices Act, was introduced on July 14th and referred to the three committees of jurisdiction. Three months later on October 14th the Energy and Commerce, Ways and Means, and Education and Labor Committees each reported out their marked up versions of H.R. 3200. To reconcile the three committee bills that were not identical after markup, the Affordable Health Care for America Act, H.R. 3692, was brought to the floor on November 7th and passed by majority vote, but with all Republicans and a few Democrats voting against the measure (Chaikind, 2010).

In the Senate the two committees of jurisdiction worked independently to develop legislation. The HELP Committee reported The Affordable Health Choices Act (S.1679) on July 15th, but the Finance Committee did not produce legislation until October 19th when it reported S. 1769, America's Healthy Future Act of 2009. Two months of negotiation followed during which time the Senate consolidated and amended the two bills into one legislative vehicle that was significantly more

conservative in its approach than the House bill. For this vehicle the Senate used H.R. 3590 which had originally been a House bill, the Service Members Home Ownership Tax Act of 2009. The language of H.R. 3590 was replaced by the compromise health reform language and named The Patient Protection and Affordable Care Act, and was passed on December 24th (Chaikind, 2010).

Before a bill can be presented to the President, both chambers must agree to and pass the same bill with identical language. When the House and Senate pass similar but different bills this usually requires a conference between the two chambers, during which time Members agree to a bill name and compromise language reconciling the differences between the two bills. This was the procedure expected to happen in January 2010 when Congress adjourned for the Christmas break on December 24, 2009 (Chaikind, 2010)

In order to fully understand the final months before the historic passage of the Affordable Care Act, one must first take into account the current place of the filibuster in Senate proceedings, and then consider the critical role that the life and death of Senator Edward Kennedy's played in the health reform effort. The filibuster is not a constitutional creation, but rather a product of Senate rules that reflects the Senate's respect for bipartisan deliberation and government restraint. For much of its history as a minority tool it was used sparingly and literally, with legendary Senate orators monopolizing floor debate round the clock for days thereby preventing votes on controversial bills. However today the filibuster has become a commonplace threat of minority obstruction, and without 60 votes to invoke cloture

on a legislative debate, the majority party is crippled in its ability to bring bills for a floor vote (Hacker, 2010).

The 2008 election had brought not only a Democrat President, but also a strong Democrat majority to both the House and Senate. The 111th Senate had 40 Republicans, 58 Democrats, and 2 Independents. One of the 58 Democrats was Edward Kennedy, the second most senior Senator and the fourth longest serving Senator in history. Kennedy had made it his career mission to pass meaningful health reform, and despite his liberal stance on health reform principles, was greatly respected on both sides of the aisle. When he died in August 2009 of cancer, the Democrat governor of Massachusetts appointed Democrat Paul Kirk to serve an interim term until a special election could be held in January 2010. This maintained the necessary 60 votes to invoke cloture and allow for passage of the Senate health care reform bill on December 24th. However the unexpected election of Republican Scott Brown to fill Kennedy's seat in the January interim election left Senate Democrats without the necessary 60 votes to pass further health reform legislation that would reflect a compromise between the House and Senate bills. With a House Democratic Caucus unwilling to accept the much more conservative Senate health reform package, it looked like the great health reform effort would die in the 111th Congress (Chaikind, 2010; Hacker, 2010).

Two individuals should be given much of the credit for keeping the health reform effort alive in February of 2010. When it seemed that the House and Senate were at an impasse, President Obama released his own compromise health reform

proposal on February 22nd that combined and modified the House and Senate bills. He then held a bipartisan summit on February 25th with key House and Senate leaders to try and reach agreement on a final legislative solution. Speaker of the House Nancy Pelosi spent countless hours negotiating with factions and caucuses within her own party, and meeting with individual Members to find a workable strategy that would allow the House to pass and amend the Senate bill (Chaikind, 2010; Hacker, 2010).

From a midwife perspective it should be noted that the only guarantee to inclusion of the CNM Medicare equity provision was the passage of either the House or Senate bill in its original form as the final vehicle. Negotiations to create a compromise final bill do not guarantee the inclusion of any or all of the original bills' provisions, and in controversial efforts a final legislative vehicle may often end up being a very stripped down version of the original bills.

After very difficult negotiations it was the use of a procedural vote that finally allowed passage of the Patient Protection and Affordable Care Act on March 21st. The House agreed to pass the Patient Protection and Affordable Care Act as long the Senate would pass a package of amendments that the House would pass separately. Because the Senate no longer had the 60 vote majority necessary to invoke cloture, the amendments would be passed utilizing a procedure known as the budget reconciliation process which only needed a simple majority to pass both chambers. The budget reconciliation process can only be used in limited situations which are germane to budgetary totals, so the amendments package still fell far

short of the House desired changes in the bill, but it was considered to be the last chance to pass any meaningful health reform (Hacker, 2010).

On March 21st the House of Representatives passed H.R. 3590, The Patient Protection and Affordable Care Act. That same day they passed the Health Care and Education Reconciliation Act of 2010 (HR 4872) which contained the negotiated amendments. The President signed the PPACA into law on March 23rd, and with it, the midwife Medicare equity provision. As agreed, the Senate passed the Reconciliation Act, but with some minor amendments, on March 25th, and the House approved the Senate amendments that same day. The President signed the Health Care and Education Reconciliation Act of 2010 into law on March 30th, and health reform was accomplished (Davis, Morgan, Stockdale, Tilson, & Hahn, 2010).

Since passage of the Affordable Care Act there have been numerous attempts by the new Republican majority in the House of Representatives to repeal all or parts of the bill. These attempts passed the House, but have not been acted on by the Democrat led Senate. Additionally 26 states led by Republican governors filed suit against the constitutionality of the health reform law. On June 28th, 2012 the Supreme Court ruled that the law did not violate the constitution. Health reform implementation will continue to move forward, and the CNM Medicare equity provision stands uncontested.

Summary

In order to better understand the two cases in this study, this chapter has reviewed the history, professional development and current status of nurse-

midwives and nurse practitioners. The policy making process was examined at both the macro and micro levels, and because two specific health policies were entwined with the CNM and NP efforts, the literature review included discussions of Medicare policy and health reform. Finally, the chapter explored CNM and NP history with Medicare reimbursement, and presented the limited body of research focused on the Medicare equity efforts of the two APRN groups.

In designing this study I chose to use a methodology that is not traditionally found in nursing research. For that reason my committee recommended the inclusion of a separate chapter that would familiarize the reader with the history, mechanics and rigor of the case study. The next chapter provides this overview of case study methods.

CHAPTER 3: CASE STUDY METHODS OVERVIEW

Methodological choice can be influenced by a number of factors including academic strengths, researcher personality and scientific epistemologies, and the particular nature of the research inquiry. Yin (2009) discusses three conditions of a research study that impact the choice of methodology: whether or not the study focuses on a contemporary event; whether or not it is possible to control behavioral events; and what specific question the researcher seeks to answer. If the researcher wants to know *who, what, where, how many, or how much* about a contemporary issue that will not require control of behavioral events, then she may choose to take a quantitative approach with a survey methodology. If the researcher is looking to answer a *how* or *why* question about a contemporary event where it is possible to control the behavioral events, then a quantitative experiment is the logical choice (Yin, 2009). If it is the desire of the researcher to understand the lived experience of a phenomenon, then the qualitative phenomenological approach would be the best choice (Streubert & Carpenter, 1999). Finally, if the researcher is seeking to answer a *how* or *why* question where there is no potential for control of behaviors, then a historical methodology would be best choice for non-contemporary incidents and the case study methodology is best suited to the contemporary event (Yin, 2009).

The case study as a methodology represents a paradox for scientists across many disciplines. Gerring states:

Although much of what we know about the empirical world has been generated by case studies, and case studies continue to constitute a large proportion of the work generated by the social science disciplines, the case study method is generally unappreciated – arguably, because it is poorly understood” (Gerring, 2007, p. 8).

In order to address any concerns or lack of familiarity with the case study methodology, the historical development of the method is reviewed and it is framed with the most comprehensive and current definitions. Then the common myths and misconceptions about the method are discussed and debunked.

Historical Development of Case Study Research

The first historical references to case study research are found in early nineteenth century French monographs. Credited with being the founder of sociological fieldwork and the case study, Frederic Le Play (1806 – 1882) developed a method to study the decline and prosperity of societies that focused on observing specific units of society in order to formulate an understanding of the characteristics of that society as a whole. His method included three sources of data collection: direct observation, interviews with individuals in the unit, and collecting information from social authorities outside the unit. Despite its early influence and long term contribution, the case study approach became associated with unpopular

societal reform efforts in the early twentieth century and subsequently disappeared from French sociologic practice and writings (Hamel, Dufour, & Fortin, 1993).

The development of the case study as a research method in the United States of America is most often attributed to the University of Chicago's Department of Sociology (the Chicago School). As LePlay's influence was disappearing in France, social workers and early sociologists in the USA began using a case study field approach to studying immigrant populations in urban communities and rural neighborhoods. When large waves of immigration reached Chicago in 1916, University of Chicago professors William Thomas and Robert Park set up a program of field studies in order to address issues of poverty, crime and deviant behavior. In time, the students of Thomas and Park became some of the leading sociologists in the country, and the tradition of case study became a hallmark of the Chicago School (Hamel et al., 1993).

The period of economic depression that followed the stock market crash of 1929 caused the country to question old ideologies, while at the same time creating a demand for precise calculations and strict adherence to numbers. The first half of the 1930s was marked by a movement within the field of sociology and other disciplines to make research more scientific. At the 1935 annual meeting of the American Sociological Society a public debate developed between Columbia University, which championed the quantitative experimental method, and the Chicago School, most known for its case study methodology. This dispute, which favored Columbia University professors, heralded the decline of professional

ascendancy by the Chicago School, and along with it the popularity of the case study methodology (Tellis, 1997).

Quantitative methodology dominated the 1940s and 1950s. But in the 1960s coincident with feminist and social movements that were redefining USA society, researchers began to question the limitations of quantitative designs. New qualitative designs were developed, and old methods were reevaluated. A century and a half after Frederic Le Play's pioneering work, the case study began to emerge again as a viable and valuable method in the social sciences (Hamel et al., 1993).

The Case Study in the 21st Century

One of the biggest challenges to the acceptance of the case study during the last decades of the 20th century was the historical absence of a strong, inclusive and multidisciplinary definition of the method. Individual disciplines described case study in terms of the topics that their field is concerned with, using terminology like decisions, events, individuals and neighborhoods. Earlier methodology texts confused the case study with ethnographic participant observation and bibliographic histories. Similar sounding constructs like the case history and the case study teaching tool further added to the confusion (Gerring, 2007; Yin, 2009).

Several contemporary scientists have contributed to our current understanding of case study definition. Charles Ragin, a sociologist whose work has been focused on methodology and political sociology, first sought to define the principle of case analysis after a workshop conducted with Howard Becker in the winter and spring of 1988. The workshop resulted in a compilation of essays

answering the question: “what is a case?” that was published in 1992 (Ragin & Becker, 1992). In the introduction to that volume Ragin offers this definition of a case: “A case may be theoretical or empirical or both; it may be a relatively bounded object or a process; and it may be generic and universal or specific in some way” (Ragin, 1992, p.3)

Robert Stake (1995), a psychologist, educator and author, offered this description fifteen years ago: “Case study is the study of the particularity and complexity of a single case, coming to understand its activity within important circumstances” (p. xi). Stake wrote that there were three categories of case studies. The intrinsic case study is one in which interest in the specific case drives the investigation. The case is not chosen because of its uniqueness or sameness, but rather because the researcher has a special interest in the case at hand, and sets out to understand the case in its totality. In the instrumental case study the case plays a supportive role to understanding a larger issue or theory. The case is chosen because it provides insight into something else. Lastly, the collective case study is an instrumental case study expanded to include several cases. The goal of the collective case study is to provide a more comprehensive inquiry into a phenomenon, population or general condition (Stake, 1995).

A political scientist, author and educator, John Gerring presented this expanded characterization:

Case connotes a spatially delimited phenomenon (a unit) observed at a single point in time or over some period of time. It comprises the type of

phenomenon that an inference attempts to explain... A case study may be understood as the intensive study of a single case where the purpose of that study is – at least in part – to shed light on a larger class of cases (Gerring, 2007, pp. 19–20).

Alexander George and Andrew Bennett (2005) are political scientists who described the case study as a category of methods which may include historical inquiries, quantitative analysis and qualitative methodologies. They defined the case as a historical instance or a scientific phenomenon:

that the investigator chooses to study with the aim of developing theory (or ‘generic knowledge’) regarding the causes of similarities or differences among instances (cases) of that class of events. A case study is thus a well-defined aspect of a historical episode that the investigator selects for analysis, rather than a historical event itself (p. 17-18).

George and Bennett upheld the position of the case study in the social and political sciences particularly because of its advantages over other methods, including the potential for fostering new hypotheses and the ability to discern causal mechanisms and address causal complexity (George & Bennet, 2005).

As an author, educator and scientist, Yin was instrumental in expanding the definition of case study research beyond its historically limited perspective of exclusive reliance on participant-observation (Platt, 1992). In the most recent edition of his case study textbook, Yin (2009) offers this expanded technical definition of the case study methodology:

A case study is an empirical inquiry that investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident. The case study inquiry copes with the technically distinctive situation in which there will be many more variables of interest than data points, and as one result relies on multiple sources of evidence, with data needing to converge in a triangulating fashion, and as another result benefits from the prior development of theoretical propositions to guide data collection and analysis (p.18).

Like Stake, Robert Yin also describes three separate, but different, classes of case study. Exploratory case studies are undertaken to look at a phenomenon, process or population when there is no theory or hypothesis about the case. They are often conducted as a prelude to a larger study, to help the researcher identify concepts and events. The descriptive case study is used when the researcher wants to illustrate a phenomenon or process in light of a presupposed theory. Explanatory case study is an attempt to investigate causation in real life interventions. The explanatory case study can be used when the experimental or survey design is not practical for the phenomenon being studied (Yin, 2009).

Yin identifies two design approaches to case study research: holistic (the case stands alone as the single unit of analysis) and embedded (there are multiple units of analysis within the single case). Both holistic and embedded designs can involve single or multiple cases, giving way to four distinct case study designs:

single case holistic, single case embedded, multiple case holistic and multiple case embedded (Yin, 2009). The figure below is a graphic description of the potential designs in a case study.

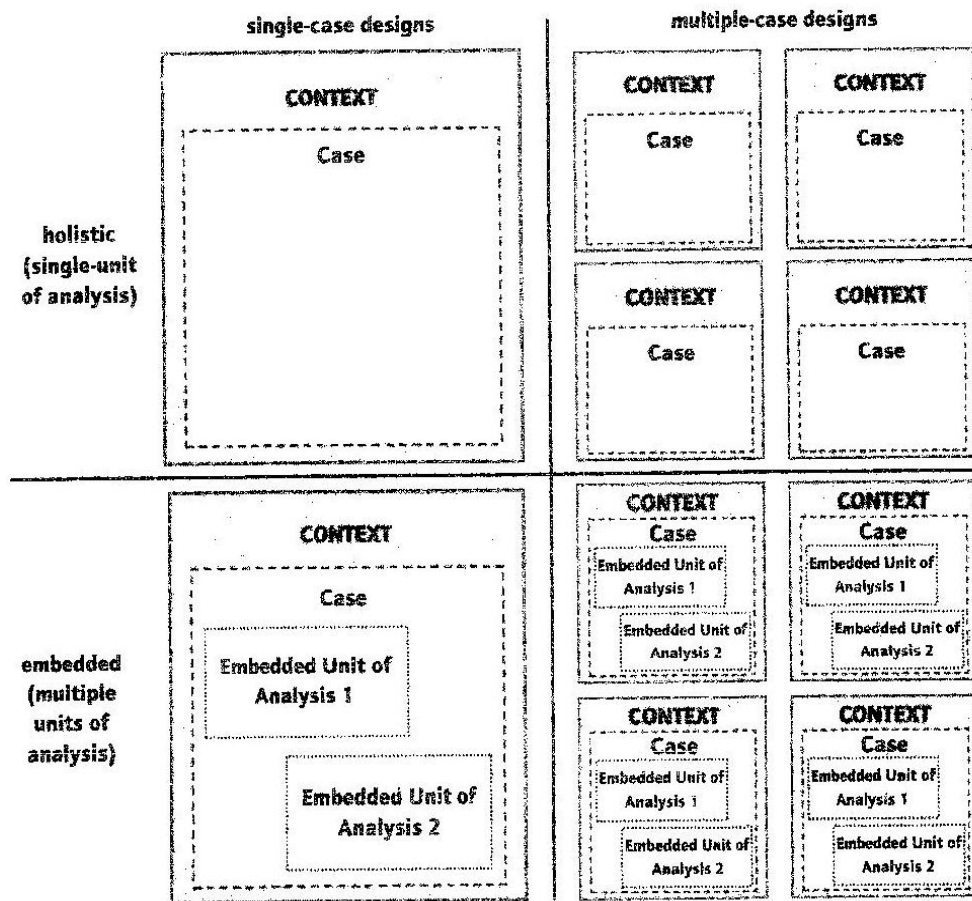


Figure 3: Basic Designs for Case Studies
Yin, 2009, p. 46

A Misunderstood Method

Several basic misunderstandings about case study research contribute to its reputation as a soft methodology because they challenge the validity, reliability and theoretical basis of the method. These have been addressed by numerous authors, but most succinctly by both Flyvbjerg and Yin. The first is that “general, theoretical (context-independent) knowledge is more valuable than concrete, practical (context-dependent) knowledge” (Flyvbjerg, 2004, p. 421). This is a positivist epistemology, and the same flawed argument could be made against any of the qualitative methodologies. Flyvbjerg contests this conventional wisdom about case studies, making the assertion that case study research plays a valuable role in human learning because of its ability to generate a nuanced view of human affairs.

The second misconception is that because case studies do not involve randomized selection they are only useful for generating hypotheses, and not for hypothesis testing and theory-building. Yin disagrees and offers the alternative belief that case studies are intimately involved with both verifying existing theory and generating new theory. Flyvbjerg additionally clarifies that the strength of case study methodology is that it allows the researcher to select extreme, critical, maximum variation and paradigmatic cases which may not have been included in a random selection process, but that can be invaluable in refuting or supporting theories (Flyvbjerg, 2004; Yin, 2009).

A third concern about case studies is that they are too lengthy and difficult to summarize. Both Flyvbjerg and Yin acknowledge the difficulty in summarizing case

studies, and Flyvbjerg offers the defense that a good narrative can both give meaningful insight into a case and point the way toward future experience (Flyvbjerg, 2004). Yin offers alternative formats for writing the case study report that include the classic single or multiple case narrative, a question and answer format, and a cross case analysis report (Yin, 2009).

The last two erroneous beliefs about case studies involve questions of their scientific rigor. There are many scientists that believe it is not possible to generalize on the basis of an individual case, and that this therefore, limits the contributions of the method. Yin disagrees and points out that neither single case studies nor single experiments are equipped to establish scientific belief, rather they both either support or refute theoretical propositions. Each subsequent replication of a case study or experiment will strengthen the theory's generalizability to larger populations. Flyvbjerg further debunks this belief by showing how the "falsification test" exemplified by the presence of the one black swan is capable of disproving the "all swans are white" proposition (Flyvbjerg, 2004; Yin, 2009). Strategies to address generalizability in this study are addressed in the following section under external validity.

The final mistaken belief about the case study methodology is that it contains a bias towards verification of the researcher's preconceived beliefs. Neither Flyvbjerg nor Yin agree with this, and assert that all qualitative and quantitative methodologies are equally susceptible to researcher bias (Flyvbjerg, 2004; Yin,

2009). This bias is an acknowledged threat to reliability / dependability and strategies to overcome are discussed in Chapter 4.

Summary

This chapter presented an overview of the case study methodology. It began by describing the role of the case study in research history. It then introduced the leading case study scientists and presented definitions of the method. Classes of case study were presented, and design approaches were described. The chapter concluded by discussing the common misconceptions and beliefs about case studies, and refuted these with approaches to increase the rigor of the method.

The next chapter will discuss the specific methodologies used in this comparative case study dissertation. It will examine the design of the study, the procedures utilized, data collection and analysis strategies. The chapter will conclude with a more in depth discussion of strategies utilized to increase the scientific rigor of this case study analysis.

CHAPTER 4: METHODOLOGY

Introduction

This study used qualitative case study methodologies to explore the midwifery Medicare reimbursement legislative process and to address the study research questions:

1. Why did ACNM and the NP organizations fare so differently in their efforts to achieve payment equity?
 - a. Why did the process take 6 years for NPs but 19 years for the CNMs?
 - b. Why were the NPs successful in achieving only 85% reimbursement while the CNM legislative endeavor resulted in 100% reimbursement?
2. What role, if any, did gender play in the CNM and NP Medicare legislative endeavors?
3. How were the efforts of CNMs and NPs to achieve equitable Medicare reimbursement impacted by special interest politics?

While a feminist ideological worldview, personality characteristics and academic strengths all contributed to the selection of the case study method, the strongest determinant for the choice of methodology was the case itself. During my career I had been involved in different capacities and at different junctures in the nineteen year CNM/CM policy effort, and sought a more complete understanding of

what had happened in this particular process or case. Stake contends that there are instances when “case study is not a methodological choice, but a choice of object to be studied. We choose to study the case” (Stake, 1998, p. 86). In this doctoral research, the midwife Medicare reimbursement case was both the research subject and defined the choice of methodology.

Design

This study used a two case variation of the multi-case holistic case study design to contrast the political processes for achieving CNM and NP Medicare reimbursement.

The design in this study was holistic because it met the two criteria by which Yin (2009) favors the holistic over the embedded design: no logical subunits can be identified, and the theories used to frame the study are holistic in nature and describe political processes and feminist worldviews. The CNM reimbursement process and the NP reimbursement process stand alone as two single holistic units of analysis.

The design for this study involved two cases in order to strengthen the study findings. This is achieved when, according to Yin “the subsequent findings support the hypothesized contrast [and so] the results represent a strong start toward theoretical replication” (Yin, 2009, p. 61). An additional benefit of including a second case involving nurse practitioners is the increased applicability and interest in this study as a teaching tool for advanced practice nurses.

Selection and Definition of Cases

As compared to experimental and quasi-experimental methods which require random sampling techniques, and some qualitative methods which rely on purposive sampling, the selection of the single case or multiple cases for a case study analysis is frequently done by means of information-oriented sampling. Flyvbjerg suggests that there are three specific types of information-oriented cases that may drive the selection of a study case or cases: the critical case, the extreme case, and the paradigmatic case (Flyvbjerg, 2004). In a situation where the researcher is interested in appropriateness of a specific theory for explaining a phenomenon, population or process in general it is prudent to utilize information-oriented sampling techniques in order to identify a case that will prove, disprove or substantiate the theory in question. There are situations, however, where interest in the specific case is the reason for the research, and in that situation the researcher chooses to study the case by utilizing a case study methodology (Stake, 1998).

In this research study it is a strong personal and professional interest in the specific CNM/CM Medicare reimbursement process that drove the methodological choice, and consequently one might argue that the midwife case was purposively selected. The selection of a second case for comparative analysis followed the more prudent path of utilizing information oriented sampling.

The theoretical framework also informed the choice of case. This comparative case study analysis uses two theoretical frameworks: Bryson's (1992) feminist political theory, and Feldstein's (2001) economic version of interest group

theory of government. Feminist theory offers a framework by which to understand the payment equity quest of two women's organizations. However, if the special interest groups in each of the two cases are virtually identical in size, resources and gender, then it is more likely that the differing outcomes cannot be attributed to feminist theory alone. The selection of the NP Medicare reimbursement effort as the second case holds constant the major variables that could account for differences in outcome, and therefore challenges Feldstein's theory to account for the variances in political course and final outcomes.

The NP reimbursement process offered a case with a deviant process and outcome from the CNM case. Determining which, if either of the cases represents the truer paradigm of a health policy process is not a critical outcome of the study. Rather the value of the study will be finding answers about why and how the two cases differed in the length of time it took to achieve equitable reimbursement and in the final amount of reimbursement achieved.

The units of analyses in this comparative case study were the bounded processes that defined each of the professional efforts to achieve equitable reimbursement, and include the events, the people, and the politics that shaped the Medicare reimbursement policies for midwives and nurse practitioners.

The nurse practitioner case began with the opening of the 102rd Congress on January 3rd, 1991, and ended with the Balanced Budget Act of 1997, which included the nurse practitioner Medicare reimbursement language, being signed into law on August 5th, 1997.

The midwife case also began with the opening of the 102rd Congress on January 3rd, 1991, but extended thirteen years after the nurse practitioner effort. This case ends with the signing into law of the Patient Protection and Affordable Care Act on March 23rd, 2010.

Procedure

The procedure for conducting this comparative case study began before the collection of data, and followed Yin's three recommended activities: skill development, preparation and training, and development of the research protocol (Yin, 2009).

Yin recommends that the researcher develop or practice the skills needed in field case work. These skills include the ability to ask good questions and interpret the answers, the quality of being a good listener, the attribute of having a thorough knowledge and understanding of the issues being studied, and the proficiency to be unbiased by preconceived personal ideas or theoretical frameworks (Yin, 2009). My professional and academic background had already established adequate interview and listening skills, and I subsequently worked to increase my knowledge base through the literature review. In order to assure that any potential bias did not lead to unsupported inferences, I consulted regularly with my committee and sought feedback on any potential biases, as well as maintained a reflective journal.

The second activity is preparation and training for the specific case study. In order to prepare and train for this case study I first developed informed consents for study participants and made application to the George Mason University HSRB

for approval of the study. A copy of the HSRB approved consent form is included in Appendix A. In addition, I scheduled one on one tutorials with committee members to enhance my analysis capabilities for the study analysis.

The final step in preparing for a good case study is the development of the research protocol. According to Yin the protocol should consist of an introduction that includes study purpose, questions and theoretical frameworks; data collection procedures that discuss access to participants, types of evidence to be collected, and human subjects protection information; a list of case study questions that will guide the field interviews and data collection; and a guide for the case study report (Yin, 2009). A concise outline of the protocol is included in the chart below and also in Appendix B. Additionally the majority of this information is discussed throughout the first and third chapters of this dissertation.

Protocol
<p>A. Outline of the Case Study Project</p> <ol style="list-style-type: none">1. Purpose of this Study<ol style="list-style-type: none">a. To formulate an in depth understanding of the politics, personalities and processes that defined the CNM/CM Medicare reimbursement effortsb. To explore how and why the process differed from the NP Medicare reimbursement effort.2. Study Questions<ol style="list-style-type: none">a. Why did the ACNM and NP organizations fare so differently in their efforts to achieve payment equity? Specifically the study will attempt to address:<ol style="list-style-type: none">i. Why did the process take 5 years for NPs but 18 years for the CNMs?ii. Why were the NPs successful in achieving only 85% reimbursement while the CNM legislative endeavor resulted in 100% reimbursement?b. How did feminist political epistemologies shape the actions and decisions of

- the players in this political process?
 - c. How were the efforts of CNMs and NPs to achieve equitable Medicare reimbursement impacted by special interest politics?
- 3. Theoretical Framework and Process Model
 - a. Feminist Political Theory (Bryson, 1992)
 - b. Feldstein's (2001) economic version of the interest group theory
 - c. Longest (2010) Model of Public Policy Making in the United States
- 4. Role of the Protocol
 - a. To clarify and guide field procedures
 - b. To standardize field procedures across cases
- 5. Creation of Audit Log
 - a. To track decisions about development of the proposal and protocol
 - b. To track decisions about data sources and sampling choices within the cases
 - c. To track decisions about selection of analytic techniques

B. Field Procedures

1. Access to case study sites
 - a. Researcher works on the Hill, therefore has access to other member office staff and committee staff
 - b. Researcher is a member and past BOD member of ACNM and has support of the organization for this research, therefore will have access to all relevant documents and CNM/CM members and staff who have been involved in this legislative effort
 - c. Researcher has approached past faculty mentor who wrote the NP reimbursement legislation and she has agreed to facilitate access to NP organizations (AANP and ACNP) and relevant members and staff
2. Human Subjects Protection
 - a. Researcher will make application to GMU Human Subjects Review Board upon approval of study proposal.
 - b. Sample informed consent form attached (see Appendix A)
3. Sources of Data
 - a. ACNM documents pertaining to legislative efforts such as minutes of BOD meetings and reports submitted by staff and volunteer government affairs leaders
 - b. NP organizational documents pertaining to legislative efforts such as minutes of BOD meetings and reports submitted by staff and volunteer government affairs leaders
 - c. Interviews with ACNM Presidents, Executive Directors, Directors of Professional Affairs, GAC and PAC volunteer leaders, and lobbyists who were involved during the 19 year legislative effort. Will sample within this group until saturation is reached.
 - d. Interviews with NP leaders and government affairs volunteers who were involved during the 6 year legislative effort. Will sample within this group until saturation is reached.
 - e. Congressional office staff and records as available

C. Case Study Questions

1. Professional Organizations
 - a. What do you remember about the Medicare reimbursement efforts of your organization?
 - a. What do you think was responsible for the non-passage of the legislation the years it saw no activity?
 - b. What do you think was responsible for the passage of the bill the year it was acted upon?
 - c. Do you recall any personalities, events or decisions that had either a positive or negative impact on the course of the legislation?
 - d. What do you think your organization did well in promoting this legislation?
 - e. What do you think your organization could have done better to promote this legislation?
 - f. Was your professional organization strategizing in a proactive effort on this legislation, or were you engaging in the process in a more reactive way?
 - g. What role do you think the size and resources of your organization had on the process and outcome?
 - h. What role do you think gender had on the process and outcome?
2. Congressional offices and committees
 - a. What do you remember about the Medicare reimbursement efforts of Nurse Practitioners/Certified Nurse-Midwives/Certified Midwives?
 - b. What do you think was responsible for the non-passage of the NP (CNM) bill the years it saw no activity?
 - c. What do you think was responsible for the passage of the NP (CNM) bill the year that it was acted upon?
 - d. Do you recall any personalities, events or decisions that had either a positive or negative impact on the course of the legislation?
 - e. Who do you remember as the primary stakeholders in the NP and CNM efforts?
 - f. What do you think professional organizations could have done differently to have altered the course of the NP (CNM) legislation?
 - g. Is there anything your office could have done differently to alter the course of the NP (CNM) legislation?
 - h. What role do you think the size and resources of the organizations had on the process and outcome?
 - i. What role do you think gender had on the process and outcome?

D. Case Study Report

1. Chronological narrative of NP Medicare reimbursement effort
2. Chronological narrative of CNM Medicare reimbursement effort
3. Evaluation of NP Medicare reimbursement effort
4. Evaluation of CNM Medicare reimbursement effort
5. Cross case comparison of NP and CNM reimbursement effort

Figure 4: Case Study Protocol

Data Collection

Data to answer the research questions were collected from interviews, reviews of CNM and NP professional documents and legislative information sources. Scholars of case study research cite triangulation of data sources as a critical procedure for validating results (Gerring, 2007; Hancock & Algozzine, 2006; Stake, 1995). Yin finds the greatest advantage of multiple data sources to be “the development of converging lines of inquiry” (Yin, 2009, p. 115). In this case study convergent lines of inquiry include professional and political records as well as the differing insights from professional participants across the timeline of these two cases.

The qualitative data collected to describe and analyze the CNM and NP cases came from two types of sources: interviews and document review. The procedure for the data collection will be described separately for each case. In addition, I also reviewed electronic congressional bill summaries and federal publications from 1965 to 2010 in order to identify any federal legislation that pertained to these two cases. This was done utilizing the Legislative Information System of the US Congress, which is a website / search engine available internally to congressional offices.

Midwife Case

The midwife case data were collected between July 2011 and March 2012. The first part of the midwife case data collection involved interviews with fourteen individuals who were involved with the midwife case over its 19 year duration. The participants were purposively selected and were contacted by email to determine

their willingness to take part in the study. Informed consent was obtained in person or via scanned and emailed consent forms. The interviews took place between July 2011 and January 2012. Six interviews were conducted in person, six were done via SKYPE, and two were completed via the phone. All interviews were recorded and then transcribed. A two page narrative summary of the interview was sent to each participant along with the transcription to verify reliability of the data. All participants verified that the transcription and narrative summaries reflected the interviews they had participated in. A sample narrative summary is included in Appendix B.

According to both Stake and Yin, sampling within the case is not a prerequisite to conducting a rigorous case study, rather the researcher attempts to gather as much information from as many sources as possible until saturation is reached (Stake, 1995; Yin, 2009). Because there was a significantly large population of midwifery organizational leaders available for interviewing, I chose to use purposive sampling of past and current executive directors, presidents, lobbyists and Professional and Economic Affairs Committee (PEAC) / Government Affairs Committee (GAC) chairs to narrow the process down. Care was taken to ensure that the sample represented a cross section of the 19 year process, and continued until saturation was reached. At that point the sample included two lobbyists, two ACNM Presidents, two ACNM Executive Directors, and two ACNM Directors of Professional Services. The remaining six participants had been a member and officer of the Political and Economic Affairs (PEAC) / Government Affairs Committee (GAC), or

the PAC, or both during the time period of the midwife case. The following table summarizes the demographics of the midwife case participants. Some of the participants had played more than one role within ACNM, hence the numbers in the “Relationship with Midwife Case” line do not add up to 14 participants.

Table 1: Midwife Case Demographics

Demographic characteristic	Participants (N=14)
Age	Age 45 or less = 2 Over age 45 = 12
Gender	Male = 1 Female = 13
Race	Caucasian = 14
Professional Status	RN, Lobbyist = 1 Professional Lobbyist = 1 Organizational Executive = 1 Certified Nurse Midwife = 10 Certified Midwife = 1
Relationship with Midwife Case	Internal ACNM Lobbyist = 1 Contract Lobbyist = 1 ACNM Executive Director = 2 ACNM Director of Professional Services = 3 ACNM President = 2 PEAC/GAC President = 5 PAC Officer = 2
Years associated with the ACNM	15 years or less = 4 20 years or more = 10

The second part of the midwife case data collection was document review. There were two types of documents reviewed: midwife organizational records and congressional bill summaries/federal records. Midwife organizational records were accessed at the ACNM national office in Silver Spring, MD in February and March of 2012. Because a piece of legislation does not appear in a vacuum, I wanted to have a better understanding of how and why ACNM became involved with the NPs in a piece of Medicare legislation in 1991. For that reason documents were reviewed dating from 1975 until 2010. These included all editions of the ACNM newsletter *Quickening* that has been published quarterly or bi-monthly since shortly after the organization was founded in 1968; and all editions of *The Advocate*, which was a

legislative newsletter published monthly from 2006 through 2008. Other records reviewed included quarterly board of directors meeting minutes from 1980 through 2010, internal documents, ACNM publications, and political testimonies of ACNM members.

The second set of documents reviewed for this case were electronic congressional bill summaries and federal publications from 1965 to 2010 in order to identify any federal legislation that pertained to this case. This was done utilizing the Legislative Information System of the US Congress, which is a website / search engine available internally to congressional offices.

The findings from all the organizational and congressional documents are summarized in a chart that is included as Appendix C.

The study additionally includes my reflective insights, drawn from the years that I was directly and indirectly involved in the midwifery case.

Nurse Practitioner Case

The NP case data were collected between March 2012 and June 2012. The first part of the NP case data collection involved interviews with 10 individuals who were involved with the NP case during its 6 year duration. The participants were purposively selected and were contacted by email to determine their willingness to take part in the study. Informed consent was obtained in person or via scanned and emailed consent forms. The interviews took place between March 2012 and June 2012. Seven interviews were conducted in person and three were completed via the

phone. All interviews were recorded and then transcribed. A two page narrative summary of the interviews was sent to each participant along with the transcription to verify reliability of the data. All participants verified that the transcription and narrative summaries reflected the interviews they had participated in.

The participants in the NP case represented a cross between a purposive sample and a sample of convenience. The NP case ended 15 years ago, and I was neither involved in the case then nor am I involved with the NP organizations today, so finding appropriate participants was more of a challenge than with the midwife case. While speaking at a NP legislative conference in early March 2012 I expressed my desire to locate individuals who had been active in NP politics during the time of this legislative effort. Two NPs self-identified and offered to participate in the study. Four others were chosen because of personal knowledge of their involvement; two were academic colleagues and two were individuals that I had worked with in my capacity as congressional staffer.

In order to identify other participants, I asked each of those original six interviewees to suggest individuals they remembered who had been actively involved in the NP case. Fourteen potential participants were identified, but tracking them down was a significant challenge because of the length of time that had elapsed since the case ended. Six individuals were located and contacted out of the list of fourteen. Two individuals declined to participate because they had very limited memories of that policy effort. The other four participated in the study. Saturation was achieved in this interview process on a number of themes, although

because of the historically uncoordinated nature of the NP effort involving a number of nursing and NP organizations, there were also distinct memories and themes that only belonged to individual participants. These will be discussed in the NP findings chapter and the final discussion in Chapter 7.

The final sample of NP case participants included three nurses and seven NPs, one of whom was also an attorney. Three participants had been organizational presidents/CEOs, four had worked in health policy positions, and one had worked as a congressional fellow. Three of the sample had been involved with ACNP, two had been part of AANP, two were with the Women's Health Nurse Practitioner organization (NANPRH), one had been involved with the Gerontological Nurse Practitioner organization, and one worked for ANA. The following table summarizes the demographics of the NP case participants. Since some of the participants had played more than one role the numbers in the "Relationship with NP Case" line do not add up to 10 participants.

Table 2: Nurse Practitioner Case Demographics

Demographic characteristic	Participants (N=10)
Age	Over age 45 = 10
Gender	Female = 10
Race	White, non-Hispanic = 9 White, Hispanic = 1
Professional Status	Registered Nurse = 3 Nurse Practitioner = 7 Attorney = 1
Relationship with NP Case	President/CEO = 3 Fed. affairs/health policy = 4 Congressional fellow = 1 Legal Advisor = 1 Grassroots activist = 2
Primary Organizational Affiliation	ANA = 1 AANP = 2 ACNP = 3 NANPRH/NPWH = 2 NAGNP = 1 No affiliation = 1

The second part of the NP case data collection was document review. As in the midwife case this included two sets of documents: organizational records describing the NP legislative efforts and congressional bill summaries. However, unlike the midwife case where one organization spoke for the profession, the multiple organizations representing nurse practitioners made this review significantly more challenging.

All of the NP organizations were fledgling groups during this political effort. The AANP was formed in 1985/86, but in the early 1990s was focused on promoting a peer-reviewed journal and establishing a credentialing mechanism. They were based in Texas, and the only policy efforts of the group were directed out of

volunteer homes. I was able to establish that there had been an AANP policy newsletter during this six year effort, but the individual who created and distributed that newsletter (and who was one of the participants in the NP case) no longer knew where the newsletters were located.

The National Nurse Practitioner Coalition, which evolved to become ACNP in 1994, had a DC presence from its inception, but functioned out of small quarters rented from other NP and nursing organizations during the early years. The first executive director was one of the interviewees and remembered that she had once had several boxes of records from that Medicare legislative effort, but wasn't sure that she still had possession of them. The ACNP began publishing a newsletter in 1996, *Nurse Practitioner World News*, and one of the participants spoke about legislative alerts being included in that publication. I reached out to the current publisher of *Nurse Practitioner World News* but they were unable to locate any of those early publications.

The only substantial set of documents that traced this legislative effort was from the American Nurses Association. I reviewed records at the ANA national office in Silver Spring, MD in June of 2012. These records included all editions of their policy newsletter, *Capital Updates*, published between 1983 through the time that the NP Medicare 85% reimbursement was signed into law in 1997. *Capital Updates* was published every two weeks from 1983 through 1999 when the federal affairs department was downsized. From 1999 until the present it has been published approximately monthly.

Finally, because midwives were included in the effort for the first 3 years of the legislation, documents reviewed for the midwife case were included where relevant to the NP case. These were reviewed at the ACNM national office in Silver Spring, MD in February and March of 2012.

The second set of documents reviewed for this case were electronic congressional bill summaries and federal publications from 1965 to 1997 in order to identify any federal legislation that pertained to this case. This was done utilizing the Legislative Information System of the US Congress, which is a website / search engine available internally to congressional offices.

The findings from all the organizational and congressional documents are summarized in a chart that is included as Appendix D.

Analysis

Strategies for Analysis

Data analysis in this case study followed in the empirical – analytical tradition of Yin, who maintains that since case studies characteristically involve complex events and behaviors that can generate multiple types of data, it is imperative to have a strategy to deal with the evidence that is collected. Yin described four strategies that can be used to organize the information into some preliminary arrangement: case description, theoretical comparison, using quantitative data to inform qualitative data, and rival explanations (Yin, 2009).

I chose to use the first two strategies to organize the data. First the collected data were organized around a historical descriptive framework of the both the CNM

and NP reimbursement processes. Then the data were organized by six categorical areas that emerged in the thematic analysis of the interviews. In the first chapter of this proposal, I posited that the CNM and NP Medicare reimbursement cases could be explained by the economic version of the interest group theory of government where political support determines the level of benefit allocation between competitive demanders; and by feminist political theory that suggests disincentives in our existing political system for women's payment equity (Bryson, 1992; Feldstein, 2006). So the final strategy for data organization was the use of the data to discuss the two theories in the Comparative Analysis Chapter.

Because no quantitative data were collected the third strategy does not apply to this case study. The final strategy of using rival theories was not employed because the data collected fit adequately into the proposed theories.

Yin (2009) further believes that the development of a case study database is critical to the organization and documentation of the case study research. Case studies have the potential to generate very large quantities of data that will include notes, documents, tabular materials and narratives. A preferred method to manage these multiple sources of data is the use of computer software. There are several choices of qualitative software, but after consultation with my dissertation committee, we determined that the ATLAS-ti qualitative software was the best choice to organize the data in this case study.

Analytic Techniques

Yin describes five analytic techniques that can be used to evaluate the data in a case study: pattern matching, explanation building, time series analysis, logic models and cross case synthesis. Of these five, he considers pattern matching to be the most desirable technique for testing theory in case studies (Yin, 2009).

In this research two of these five analytic techniques were used. The first was pattern matching, which consists of matching an observed pattern with an expected, or hypothetical, pattern. Hak and Dul believe that in pattern matching it is essential to precisely define the expected pattern before the matching begins. This is different from pattern recognition, where variables are observed and then a pattern is theorized (Hak & Dul, 2010).

In this case study, pattern recognition was used in the analysis of interviews to identify the categories, themes and subthemes. The analysis of the interviews began with listening to each audio recording and reviewing the accuracy of the transcription. Next each transcription was reviewed again in order to write a summary of the interview. Then the transcription was reviewed a third time and codes were assigned to relevant parts of the interview.

In order to assure myself that I was coding the transcriptions accurately, three blank transcriptions were sent to one of the Committee methodologists along with three matching coded transcriptions. The Committee member coded the three transcriptions, and then compared her codes with my codes. The Committee member verified that I was coding accurately, and offered a few suggestions for

alternative code naming which I then incorporated into the remaining transcriptions.

Next the codes from the interviews were entered into ATLAS-ti software for analysis. This software assisted me to organize the coded data, and to search for commonalities or patterns between sources of data. In the midwife case there were initially 347 codes attached to 620 quotations. The codes were reviewed multiple times to find commonality, merged where appropriate, and duplicates were removed. When no more overlap was found, the final total number of CNM codes was 226, and these were attached to 579 quotations. In the nurse practitioner case there were initially 287 codes attached to 383 quotations. These codes were reviewed for commonality and overlap, merged where indicated, and duplicates were removed. The final number of NP codes was 185 and these were attached to 378 quotations.

The next step was to identify the common themes throughout the coded interviews. The ATLAS network view manager was used to help classify categories and relationships throughout the 226 codes from the CNM case and the 185 codes from the NP case. Five distinct categories were delineated: Policy Agenda, Policy and Political Process, Relationships, Organizational Capacity and Political Competence. It was noted that Gender cross-cut several of these categories, and so Gender was included as an additional category. Finally the ATLAS family manager was used to assist in identifying specific themes and subthemes within each of the categories.

Then pattern matching was used to compare the historical narratives and the thematic analyses of the two cases with the hypothesized theoretical frameworks. The historical narratives, along with the 19 themes and 29 subthemes that were identified in the CNM case, and the 19 themes and 26 subthemes identified in the NP case, were first compared with Bryson's (1992) Feminist Political Theory, and then with Feldstein's (2001) Economic Version of the Interest Group Theory in order to determine pattern matching. These patterns were then utilized to answer the study research questions.

The second analysis technique was cross case synthesis, which applies only to the study of two or more cases. In cross case analysis each case is considered as a separate study and analyzed according to one of the techniques previously discussed. Analysis of the individual case may have been done by an earlier study, or may be a part of the current study. Data from each separate analysis are displayed in a word table based on some uniform framework, and then comparisons are made across the word tables, looking for the presence of similarity and/or unique differences in the cases (Yin, 2009). In this research, comparisons between the midwife case and the nurse practitioner case were first discussed in a section on Historical Comparisons, and then the six thematic categories were compared across the two cases for differences and commonality in the identified themes and subthemes. Finally, the data from the thematic comparisons were displayed in a table that shows commonality and differences.

Peer Review

In order to ascertain the accuracy of the qualitative findings, midwife and nurse practitioner peer reviewers who had not been involved as interviewees were used at two junctures in the analysis. The first was the historical narratives. For the midwife case, three auditors who had been actively involved in ACNM during the entire time frame of the Medicare equity quest were asked to review the historical narrative for accuracy. For the nurse practitioner case, two auditors who had been actively involved in NP politics during the time frame of the Medicare legislative effort were asked to review the NP historical narrative for accuracy. A summary of their comments and verification of the narratives are discussed in the peer review sections of the CNM and NP findings chapters.

The second use of peer review was for the thematic analyses. Three midwife qualitative researchers who had long involvement with ACNM were asked to review the midwife analysis of themes for correctness. Two RN/NP qualitative researchers were asked to review the NP analysis of themes for correctness. A summary of their comments and confirmation of thematic analysis are also included in the peer review sections of the CNM and NP findings chapters.

Scientific Rigor / Trustworthiness

While the prevailing tradition among many qualitative researchers is to equate scientific rigor with accurate representation and confirmation of information discovery, Yin believes that the same processes that have been historically used to ascertain the quality of any empirical research should also hold true for the case

study methodology. These four tests are: construct validity, internal validity, external validity, and reliability (Yin, 2009). For the purposes of establishing the scientific rigor and trustworthiness of this case study comparative analysis, each of the tests will be addressed and techniques to satisfy them will be delineated in the next section of this chapter. Wherever applicable, they will be compared to the four processes traditionally employed to establish rigor in qualitative studies: credibility, dependability, confirmability and transferability.

Construct Validity

The first and most challenging test of rigor for case studies is construct validity, which Yin defines as isolating precise operational measures for the study components (Yin, 2009). One of the ongoing criticisms of case studies is the use of subjective judgment in the collection of data because the researcher has failed to establish operational measures for the study. Yin offers three tactics to increase the construct validity of case studies: the use of multiple sources of data, a chain of evidence, and the use of key informants to review the findings (Yin, 2009).

All three of these strategies were used in this case study in order to increase the construct validity of the research. The sources of data used in these case studies included multiple types of documents, and interviews with professionals involved in both the midwife and nurse practitioner cases. I maintained a journal documenting the chain of evidence in the study. Additionally, key informants were used at two different junctures in the analysis to verify accuracy.

Internal Validity

Internal validity applies to explanatory and causal studies but not to descriptive or exploratory studies. Although typically used to evaluate the causal relationships in quantitative studies, the terminology can also be ascribed to some qualitative studies. In this case, “internal validity is an issue of how well the particular relationships described in the research actually can be ascertained to be the primary dynamic at play, rather than an artifact of some other process” (Yue, 2010). Yin believes that in case study research internal validity is important to address the tendency towards making inferences, and offers four analytic tactics to satisfy its rigor: pattern matching, explanation building, addressing rival explanations, and using logic models (Yin, 2009). In this study pattern matching was used to satisfy internal validity. Analysis revealed theme repetition both within and across the two cases, and the matching of these themes to established theories supported the validity of the findings.

External Validity

External validity refers to “generalizability: the ability to take the findings from one study and apply the same relationships and conclusions to other populations and contexts” (Yue, 2010). In qualitative research this test of rigor is generally described as transferability, also known as fittingness, “a term used in qualitative research to demonstrate the probability that the research findings have meaning to others in similar situations” (Streubert & Carpenter, 1999). External

validity has historically created challenges for the case study methodology because single cases lack the sample size for generalization to larger universes. But Yin disputes the analogy to survey research by asserting that: “survey research relies on statistical generalizations, whereas case studies (as with experiments) rely on analytic generalization. In analytic generalization, the investigator is striving to generalize a particular set of results to some broader theory” (Yin, 2009). Therefore Yin suggests that external validity can be satisfied in multiple case study designs by using theory and replication logic. In this study I was able to generalize each of the two case studies to existing theories. Furthermore, the transferability of the research findings is demonstrated in the interest shown by the participants in each of the cases for the findings associated with the comparative case, and will be further be validated through presentations of study findings at advanced practice nursing conferences and nursing policy symposiums.

Reliability

The final test for rigor is reliability. “Reliability assesses the extent to which the results and conclusions drawn from a case study would be reproduced if the research were conducted again” (Ward & Street, 2010). Qualitative researchers often refer to reliability as dependability, a criteria that rests on the establishment of credibility. Dependability takes credibility one step further and asks if the findings are trustworthy (Streubert & Carpenter, 1999). McGinn suggests that credibility (and hence dependability) can be enhanced by the use of peers, external

consultants, or auditors to review and verify the evidence (McGinn, 2010).

Reliability is also similar to the qualitative test of confirmability, but goes the step beyond the ability to recreate a process and asserts the reproduction of results and conclusions. Yin suggests that reliability will be satisfied if the researcher documents a case study protocol, develops a case study database, and maintains a chain of evidence throughout data collection and analysis (Yin, 2009). In this study I utilized all three of these activities to satisfy reliability. The case study protocol is documented in Appendix B, and Atlas-ti was used to create a case study database. Additionally I maintained a journalistic log tracking decisions about the problem statement and research questions, the theoretical framework, the content of the literature review, the methodology, and discussions about data collection and analysis.

Ward and Street additionally offer the techniques of using multiple researchers for inter-rater reliability, and employing triangulation across data sources (Ward & Street, 2010) In this dissertation it would not have been ethical or scholarly to employ multiple researchers, so reliability / dependability is addressed through the case study protocol, triangulation across data sources, and by the selection of key individuals in each of the two professions to review both the historical narrative summaries for trustworthiness of the findings, and the thematic analysis of interviews for reliability of the findings.

Credibility

There is one final qualitative process that does not have a parallel in traditional quantitative tests of rigor because of the nature of the data collected in quantitative research is inherently different from qualitative data. Credibility, which could loosely be defined as believability or face validity, is achieved when study participants recognize the reported research findings as their own experiences. This is sometimes referred to as “member checks” (Lincoln & Guba, 1985; McGinn, 2010). In this research study all participants were sent two page narrative summaries of their interviews along with a copy of their transcribed interview and were asked to review their narratives for verification of accuracy.

Ethical Considerations

Every researcher has a personal and professional responsibility to ensure that their study meets certain moral and ethical considerations. Beauchamp and Childress identify four principles of ethics to guide health care researchers in that effort: autonomy, non-maleficence, beneficence and justice (Beauchamp & Childress, 2001).

Autonomy acknowledges a person’s right to hold views, make choices, and to take actions based on personal values and beliefs. Respect for autonomy requires that the participants in the study do so voluntarily and that they are adequately informed in the consent process (Beauchamp & Childress, 2001). Voluntary participation was not a concern when soliciting CNMs and NPs to take part in the study. Of the 15 individuals that were approached to take part in the CNM case

research, 14 readily agreed to participate. The one individual who declined did so because she felt she did not remember enough about the case. Of the 11 individuals who were approached to be interviewed for the NP case, one also declined for similar reasons.

Respect for autonomy also demands a rigorous informed consent process. Crafting a thorough informed consent tool is a challenge in qualitative research because of the inherent unpredictability of the of the qualitative research process (Ramos, 1989). I worked diligently to develop the most comprehensive informed consent document possible while at the same time keeping it general enough that it would not deter participation in the study.

Non-maleficence recognizes the importance of inflicting no harm on the research participant. Respect for non-maleficence challenges the researcher to ensure that the information shared during qualitative interviews does not cause the participant any harm. This is best accomplished by assuring anonymity and confidentiality for research participants (Beauchamp & Childress, 2001) Unfortunately, the nature of most qualitative research, and case study interviews in particular, precludes anonymity. None of the professional organization participants were concerned about remaining anonymous and they did not consider their interviews confidential. Nonetheless, a general classification (such as past president, past government affairs committee chair, executive director) has been used instead of the individual names to enable anonymity in reporting.

Beneficence seeks to maximize the benefits for research participants. Respect for beneficence confers an obligation to help others further their important and legitimate interests (Beauchamp & Childress, 2001). In this study both of the nursing professional groups have a vested interest in the findings of the study. I worked hard to carefully balance maintaining thoughtfulness and objectivity during the analysis of the data with a need to produce timely and coherent summaries of the research findings.

The principle of justice indicates that all participants will be treated with fairness and equity before, during and after the study (Polit & Beck, 2012; Polit & Hungler, 1999). In this study, every attempt was made to ensure that sampling within the ACNM and NP organizations was done with fairness and equity. There was one CNM and one NP who chose not to participate in the study and I was careful not to show any disappointment or disapproval with their decisions.

A final ethical consideration in this study is the issue of researcher as participant in the study. I began this dissertation by stating that I had been involved in the CNM/CM legislative effort both as a member advocate, and as a congressional staffer. The challenge was in maintaining a degree of objectivity as researcher, while also allowing for personal insights as a participant in this particular case study process. I made every effort to avoid sharing personal reflections or “leading” the participants during the interview process, which could have created a significant researcher bias towards verification of a personal hypothesis. This same level of

objectivity was critical during the interpretation and reporting of subjective interpretations in this case study.

Summary

Chapter 4 described the case study methodologies used to explore the efforts of CNMs and NPs to achieve Medicare reimbursement equity. The study was a two case variation of the multi-case, holistic case study design. The research protocol was discussed, and procedures to collect relevant data from archival documents, political and professional documents, and interviews of professional organization leaders were outlined. Strategies for case description and theoretical comparison were delineated, and the analytic techniques of pattern identification, pattern matching and cross case synthesis were reviewed in relationship to the collected data. The chapter concluded with an in depth discussion of strategies utilized to increase the scientific rigor of this case study analysis.

The findings of this comparative case study will be organized over the next three chapters. Chapter 5 will present the findings from the midwife case, and Chapter 6 will portray the findings of the nurse practitioner case. Finally Chapter 7 will discuss the findings from the comparative case analysis of the CNM and NP cases.

CHAPTER 5: FINDINGS OF THE MIDWIFE CASE

The purpose of this study was to formulate an in depth understanding of the politics, personalities and processes that defined the midwife Medicare reimbursement effort, and to explore how and why that process differed from the nurse practitioner Medicare reimbursement effort. This chapter contains the findings of the midwife case which was defined as beginning with the opening of the 102rd Congress on January 3rd, 1991, and ending with the signing into law of the Patient Protection and Affordable Care Act on March 23rd, 2010.

This chapter is organized around two techniques that were used to analyze the midwife case. First the “Historical Narrative” summarizes data collected in the documents review that has been triangulated with the historical data in the midwife interviews. Second the “Analysis of Interviews” summarizes the themes that were discerned from the collected midwife interviews. Finally the “Peer Review Discussion” summarizes feedback from the peer review process and explains how that feedback was addressed.

Historical Narrative

The “Historical Narrative” was written using the findings from both the document review and the interviews. While most of the interview data were composed of the participants’ personal insights about the process and will be

discussed next in the section on thematic analysis of interviews, the first question in the interview asked the participant to recount what they remembered historically about the midwife effort to achieve Medicare equity. Where this section of the interview data could be validated historically with documentation, it is included to both enhance and enrich the historical narrative. Codes are used to identify the individuals who provided the data (e.g. MW01 is midwife interviewee number 1).

The narrative is divided into two sections. The first section describes ACNM efforts in regards to federal payment prior to 1991. The second section is the time period encompassing the midwife case, from 1991 through 2010. The following timeline summarizes the high points of the midwife Historical Narrative (Figure 5) .

Midwife Medicare Reimbursement Timeline

Blue years = Democrat Congress
 Purple years = Divided Congress
 Red years = Republican Congress

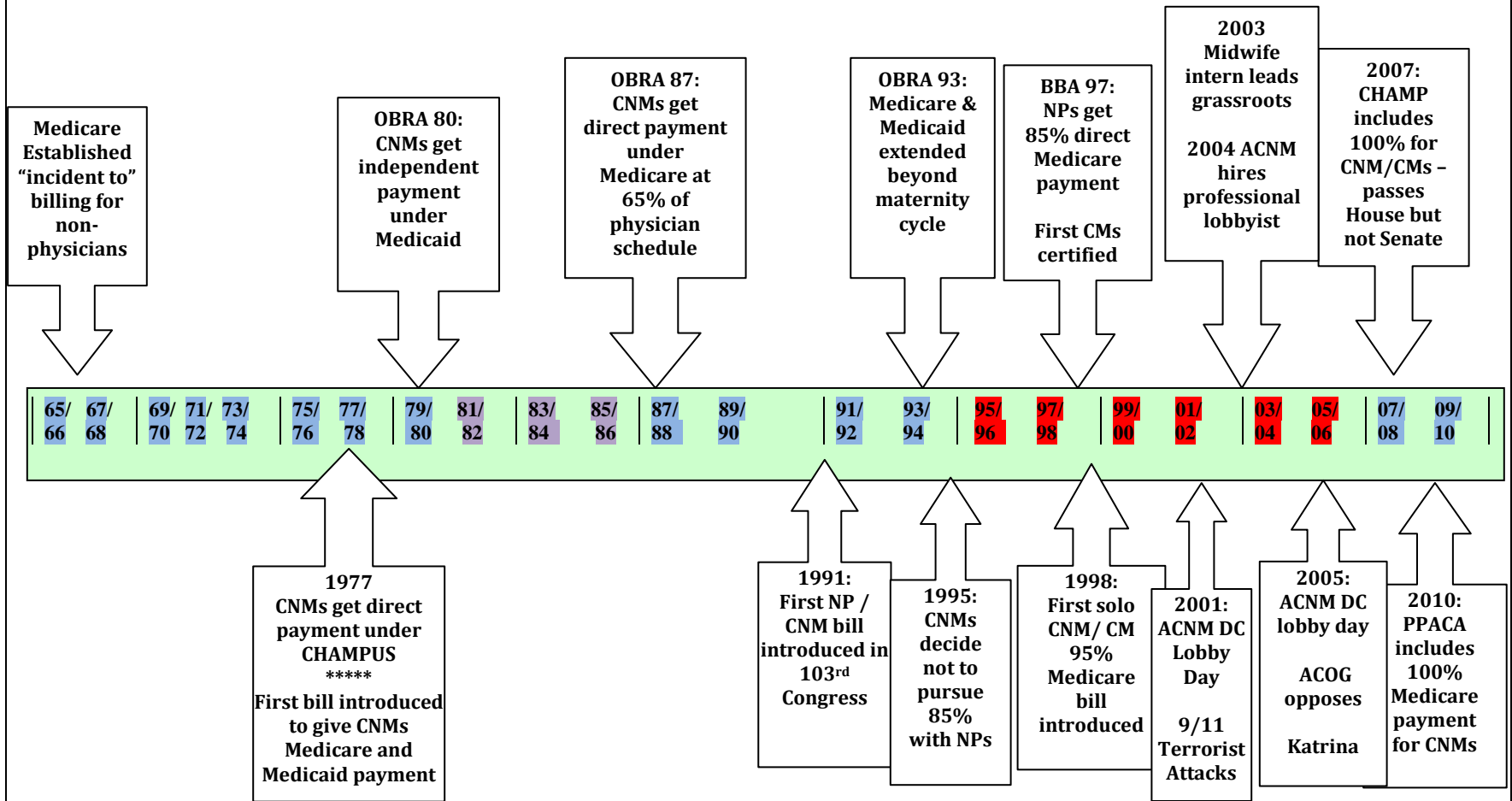


Figure 5: Midwife Medicare Reimbursement Timeline

Midwives and Payment under Federal Programs

Although the midwife case by definition begins in 1991 with the introduction of the first bill to address Medicare equity, ACNM had their debut with federal payment legislation in 1977. President Carter (D-GA) had just come to the White House, and the 95th Congress had Democrats controlling both the House and Senate. Congress passed legislation introduced by Senator Inouye (D-HI) to allow CNMs and Psychiatric Nurses to be independently reimbursed under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), which is the military insurance program. This was the first time that nurse-midwives had been recognized by name in any federal legislation.

That same year Senator Inouye introduced S. 1702, “A bill to amend Titles XVIII and XIX of the Social Security Act to provide for the inclusion of services rendered by a nurse midwife under the Medicare and Medicaid programs”. Midwives were not yet organized politically to advocate for the bill, and the 95th Congress came to a close without any action on the CNM bill.

The 96th Congress began in 1979, and Senator Inouye introduced the legislation again as S 656. This time Congresswoman Mikulski (D-MD) joined the effort and introduced the House companion bill (HR 3531). ACNM hired Sally Tom as their first lobbyist in 1980. In response to reports of disparities in perinatal outcomes, the Congressional Budget Office released a report entitled “Better Management and More Resources Needed to Strengthen Federal Efforts to Improve

Pregnancy Outcome". The report included a recommendation for greater use of nurse-midwife teams. Congresswoman Mikulski introduced two other slightly modified versions of HR 3531 during that Congress (HR 6349 and HR 6777), and Congressman Rangel (D-NY) introduced HR 4000, the Medicare and Medicaid Amendments of 1980, which included language to cover the services of nurse-midwives under Medicaid, regardless of supervision, and limited to care that was provided during the maternity cycle. The Omnibus Reconciliation Act of 1980 included HR 4000, and when it was signed into law on December 5, nurse midwife obstetrical services were covered under Medicaid. Midwife care of gynecological patients was not authorized for Medicaid payment.

The 97th Congress began in 1981 with a significant shift in political power. Ronald Reagan (R-CA) had defeated the one term President Carter, and Republicans now controlled the Senate. Congresswoman Mikulski and Senator Inouye introduced HR 4637 and S 161 to provide coverage under Medicare for CNM services. The bills saw no action that Congress, nor did the bills Mikulski and Inouye introduced in the 98th Congress (HR 2652 and S 177).

In 1985 the 99th Congress began with Ronald Reagan having won a second term as President. Senator Inouye introduced S 146 in a renewed attempt to provide Medicare coverage for CNMs. But Medicare was not high on the political agenda for midwives that year because they now faced an impending malpractice crisis that threatened to drive them out of practice. All insurance carriers had decided to drop CNMs due to their low premiums and low numbers, despite the fact that they also

had a low incidence of claims. Seventy-five midwives came to Washington, DC to lobby Congress for help with the malpractice crisis. The Energy and Commerce committee held hearings on the malpractice shortage and the plight of midwives, and before the 99th Congress adjourned they passed the Risk Retention Amendments of 1986 (HR 4301) to make greater insurance options available.

With the malpractice crisis behind them, ACNM could once again turn its attention to advocating for Medicare reimbursement. Senator Inouye introduced S 124 to provide for coverage of nurse-midwife services under Medicare. The House Medicare Amendments of 1987 (HR 2864) included language from Inouye's bill (S 124), and when the Omnibus Budget Reconciliation Act (OBRA) of 1987 passed, it included a provision that established direct Medicare payments for CNM services, limited to the maternity cycle, at 65% of the applicable prevailing charge for the same service when performed by a physician. MW13 looked back at that milestone:

I remember when the first bill was passed and we were able to get reimbursed under Medicare. My recollection at the time was that we were the first non-physician group to be able to be reimbursed when that law changed. But anyway, I remember the law being passed and what a big deal that was.

Because up until that point if you were lucky and somebody would hire you and pay you then you could work, but you couldn't get directly reimbursed. So then we could and that was exciting. And then my recall at that time was that 65% didn't sound so bad cause it was better than nothing.

However, MW14 had a slightly different memory:

We were able to in most states able to negotiate the Medicaid reimbursement very easily, and well there were a couple of hold outs. So I think that when the Medicare went through at 65% people were horrified.

Initially, 65% of the physician fee-for-service charge was workable, especially given the small numbers of Medicare patients that were eligible for maternity benefits. But passage of OBRA1989 made changes to the Medicare physician fee schedule, replacing the traditional fee for service payment with a lower reimbursement calculated by a resource based relative value scale. The Physician Payment Review Commission (PPRC) elected to extend the 65% non-physician reimbursement levels to this new scale. MW10 spoke about how this decision impacted midwives:

Now in the 70's everything was on reimbursement. So you submitted your bill and if it was reasonable you were reimbursed. If it was not reasonable you were either not reimbursed at all or they paid you a specific amount that was "usual and customary". As we evolved it became clear that the reimbursement on the usual and customary or just a reimbursement for services was not going to continue happening. So, different parameters were put into place in order to become more average as to what like reimbursements would be. So while... physicians were paid 100% of what was considered usual and customary, midwives were paid 65% of that. That was sufficient at that time to be able to practice. Once these "caps"... started getting placed on services rendered, then 65% of that was not reasonable to be able to provide care.

In the months that followed there were reports that private insurers were using the new Medicare payment scale to justify lower payments to nurse-midwives.

According to MW10:

Once those payment structures started getting put into place and becoming a national benchmark, for lack of a better term, all of the commercial insurances began looking to Medicare as the standard for payments. Because there was so much variability the commercial insurers wanted to have some standardization. And in order to have the standardization they could not get together and say, "okay what are we going to set?" because then you get into the anti-trust laws. So they began to look to Medicare, and I am not saying they did not do it before but not as structurally. And they began to look at Medicare to say "this is the gold standard". And so insurances then, would offer the contracts to physicians and would then reimburse midwives at 65% of the physician fee schedule because that's what the Medicare rules were.

ACNM became concerned that other government insurance programs would also begin to follow this precedent, and so began searching for a legislative solution to the problem.

Midwives and Medicare Equity

The first legislation to address increased Medicare reimbursement for nurse-midwives, nurse practitioners, and clinical nurse specialists was introduced in the first session of the Democrat led 102nd Congress by Senators Chuck Grassley (R-IA)

and Patrick Moynihan (D-NY). The *Primary Care Health Practitioner Incentive Act of 1991 (S 2103)* included a 97% reimbursement rate, and authorized incentive grants for CNMs, NPs and CNSs to work in Health Professional Shortage Areas (HPSA). (HPSAs are geographic areas, population groups or facilities that are designated by HRSA to have a shortage of health professionals.) MW01 talked about the decision to ask for 97% of the physician fee schedule, and the controversy that resulted from that decision:

The first bill was introduced in 1991. And we were in a coalition with the nurse practitioners and the clinical nurse specialists. And when we looked at the formula for the Medicare payment, we said - we hadn't done a study yet then - we said well my gosh, the only thing that is different about our work effort and our cost to do business is our malpractice, and malpractice is 4% of the formula. So we as a group, after round and round and round, decided because we averaged the group, that we would take a 3% cut. So the bill was introduced by Senators Grassley... and... Moynihan. And it was called the Primary Care Health Practitioner Act of 1991. And then that year I don't believe we had a House bill yet. There was a lot of in fighting around nurses, we did not have the support of the American Nurses Association. They actually thought that that number - 97% of the physician fee schedule - was too high. And so we have these major problems for entire year.

During the second session of the 102nd Congress Representative Ed Towns (D-NY) introduced *HR 4963*, the *Primary Care Health Practitioner Incentive Act of*

1992, as a companion bill to S 2103. The nursing community came together this year and nurse-midwives worked in coalition with other advanced practice nursing groups to promote the legislation. MW01 describes the change:

So in 1992 we finally got everyone in the leadership together. And we had a nursing reimbursement conference that we had with ACNM, AANP and ANA. And this was just to get people back on board, and to show the value that nurse practitioners brought to the table.

ACNM produced its first legislative manual that year, and the lobbyist worked hard to educate the membership about the importance of Medicare equity. MW13 remembers the members rallying around the 97% argument:

And some other things I remember from that time were the very careful work to calculate the relative value, those numbers. I still have some of those old buttons, including some that said 97%. There was a 97% piece for a while that had to do with the difference of what it cost us to buy malpractice insurance or something. But I remember us making the argument that it didn't cost us any different to sterilize a speculum or light an office or heat a building. But there was – it was either malpractice or the debt – but the debt argument went away after a while because our students acquire a fair amount of it as well.

The 103rd Congress began in 1993 with Democrats still controlling both the House and Senate. Now there was also a Democrat in the White House, and the 42nd President Bill Clinton (D-AK) began to push his agenda of health reform. ACNM hired its first Director of Professional Services, and instructed its lobbyist to spend 8

hours a week advocating for expansion of midwife scope of practice in Medicare and Medicaid. MW07 describes the political conversation that was taking place at ACNM that year:

So by the time I got there in 1993 I think among other things the scope of nurse-midwifery practice has broadened much more into the GYN area so we had a lot more midwives who couldn't get reimbursed for doing GYN care and who weren't happy about that. And of course there has never really been a good explanation for why our services were valued at 65% of what a physician did. So at some point after I got there, and maybe almost from the very beginning... there was a commitment made and a goal set to get reimbursement for GYN care, and then to try and increase the reimbursement.

The year 1993 was a critical time for CNMs. The HHS Office of the Inspector General released a report (OEI-01-90-62070) that recommended enhancing utilization of non-MD providers and identified barriers to the expansion of CNMs and NPs. One of those barriers identified was reimbursement policies. That same year, amendments offered by Congressman Bill Richardson (D-NM) and Senators Jay Rockefeller (D-WV) and Patrick Moynihan to extend the payment of nurse-midwives in Medicare and Medicaid beyond the maternity cycle were included in the *Omnibus Budget Reconciliation Act (OBRA) of 1993*. When *OBRA 93* was signed into law in August 1993, midwives were recognized as providers of gynecology / women's health care under both Medicare and Medicaid.

The second session of the 103rd Congress brought renewed attention to raising the Medicare reimbursement rate. MW01 spoke about efforts that year:

So 94 was the kickoff year, because that was the year when CHAMPUS adopted the Medicare payment structure and reimbursement for nurse-midwives went from 100% to 65% by the end of the year. So our membership really got energized then... The first legislative conference was held since the malpractice problems (we'd had a conference back there). We did that massive conference, which was wonderful. We had great people there: Bill Richardson from Energy and Commerce, Hoyer, Jim McDermott, Rockefeller, they all came to the conference and that it was a really good thing.

In 1995 the 104th Congress brought a new Republican majority to the House and Senate, and two concerns arose for ACNM. The American Nursing Association was increasingly working to define advanced practice nurses as having a master's degree. This was a problem for ACNM, which still supported the certificate route to midwifery. So when nurse practitioners began discussions about changing the bill to 85% reimbursement, ACNM decided to withdraw from the coalition and pursue solo legislation. MW07 describes that decision:

And then the nurse practitioners decided to go for 85%... And as related to that... that kind of happened at around the same time that there was debate over entry level to practice. And the debate amongst the nurse practitioner / nurse midwife community was whether or not a master's would be required as entry level to practice. And the nurse practitioners adopted master's degree

before we did... Anyway, when the nurse practitioners went after 85% they wanted language in there that you had to have a master's degree. And certainly at that time in our history as a profession we still had a lot of nurse-midwives who were not master's prepared. We still had several programs, I don't know how many, that didn't require a master's degree. So at that time in our history it would have been a sell out to our members to say that you could only get reimbursed if you had a master's degree. So we made a conscious decision, we being ultimately our Board, to not put our name on that legislation and try and get higher reimbursement.

It proved to be a fateful decision. The *Primary Care Health Practitioner Act of 1995* and *1997* did not include CNMs, and when the bill passed in as a part of the *Balanced Budget Act of 1997*, nurse practitioners and clinical nurse specialists received 85% reimbursement under Medicare and nurse-midwives were stuck at 65%. MW14 recalled that there were a lot of hard feelings over that decision to separate from NPs:

And then when the nurse practitioners went forward and got 85% there was a lot of annoyance among many of the Senators and House Members that had worked with us so that we wouldn't just settle for 85%, and that we were sort of cutting off our nose to spite our face. This was just a silly move on our part. And I think there were many people in the College who agreed with that, you know, that this was like, why did we make that decision? And how did that decision really get made?

The American College of Nurse-Midwives, however, had not been idle while the NPs were pursuing their legislation. In 1997 ACNM replicated the Harvard study that had developed the resource based relative value scale (RBRVS) that was being used by Medicare in order to determine how those should apply to midwives. The study showed that the only difference from MDs was a slight variation in malpractice costs, and so the BOD determined to continue to seek 97% reimbursement. MW01 talked about the frustrations of disseminating that research:

By then we had... finished our research to replicate the study that had been done for the physicians, that Harvard had done. And we replicated, Health Policy Alternatives was able to get and pool from the study the same CPT coding that they were asking them to evaluate the questions on. And so we had a team locally... I can't remember the time sequence, but when the study was finished... to testify and present our research to the physician payment review committee. And they asked lots of questions; they didn't believe it. It was the philosophy that more education not outcomes means you should be paid more.

Representative Towns introduced the first solo CNM Medicare reimbursement bill, the *Certified Nurse Midwife Medicare Services Act of 1998 (HR 4872)*, in the second session of the 105th Congress. Although the ACNM Board of Directors (BOD) had set a goal of 97% reimbursement for its membership, for political reasons they agreed to a compromise reimbursement of 95%. By this time ACNM was certifying a non-nurse pathway to midwifery, and so the Certified Nurse Midwife Medicare Services Act included reimbursement for both CNMs and CMs.

The new bill also included provisions for reimbursing midwives for resident supervision, and for birth center payment. MW07 discussed national office efforts to raise awareness of the need for midwife Medicare equity:

I think the hardest part probably for anybody who is trying to do that is to figure out at what angle you come at it. You know, obviously, you have to have legislation. But with the size of our organization it's hard to say we're just going to bring legislation and get it passed without having support from the real policy makers in the DC area. Like I remember MedPAC, and I certainly remember multiple visits with people in Health and Human Services, multiple legislative conferences when we were bringing our members in.

There was no Senate companion bill introduced in the 105th Congress, despite a dramatic increase in midwives' legislative activities. ACNM hired the Washington Firm lobbying group to develop and implement a lobbying strategy, and initiated an "Adopt a Legislator" Program to encourage their members to become more politically active. Additionally they hired Muse and Associates actuarial firm to conduct a cost analysis of the bill. MW04 discussed her personal growth in political awareness:

I remember learning a lot through the process. I remember sitting through the presentation done by, and if I had a memory I would remember who did the cost analysis for us originally. Was it the Lewin group? I remember being introduced to the term "budget dust". I remember sitting in the conference room listening to that presentation, and they were really positive and I

remember sort of thinking, I didn't know, that was again part of what are the components of a strategy. You have to have, it has to be scored, you have to have a cost analysis.

In the Republican led 106th Congress Mr. Towns reintroduced the *Certified Nurse Midwife Medicare Services Act of 1999 (HR2817)* with the same provisions as the previous bill. That year ACNM formed a political action committee (PAC) and established a "Capital Connection" on their website to make legislative efforts easier for their members. ACNM continued to advocate for a sponsor in the Senate, but during that summer of 1999 their lobbyist became ill. She took a leave of absence that lasted a little over a year, and ACNM participants described a period of confusion about who was going to take over the bill advocacy.

In 2000 ACNM added the services of the Federal Group as a legislative consultant. They sponsored a lobby day in March, and 60 midwives made Hill visits promoting *HR2817* and seeking Senate sponsors for a bill. MW02 remembers that year he worked with ACNM:

So when I came on board – I originally came on board for what was supposed to be a month helping out... because she was ill and needed some help. And a month turned into a year... And at that time the Medicare bill was out there but it included several other pieces. It included the freestanding birth center language, and it included another piece which I forget, but I think there were like three provisions included in it. And the reimbursement part of it was asking

for 95% reimbursement. Then (she) came back and I wasn't involved with ACNM for about a year.

ACNM contracted with Membership Marketing Services to fund raise for the Midwives PAC, and by the end of 2000 the membership had contributed \$98,000 to the Medicare equity effort. Their efforts paid off when Senator Kent Conrad (D-ND) introduced *S2523, the Promoting Access to Medicare Midwifery Services Act of 2000* as a companion to *HR2817*. MW01 recalls the high note on which that difficult year ended:

The other thing that happened in 2000 was that we raised over a hundred thousand dollars on the PAC, one hundred thousand dollars, which was phenomenal for our size membership... People were getting hit with money, they were getting dumped by managed care, in New York Sigma, the biggest payer dumped all the nurse midwife services when they went to managed care. People were struggling financially so badly that the members finally got it.

The 107th Congress brought GW Bush to the Presidency, with a Republican House and a split Senate. Representative Towns introduced the *Certified Nurse Midwife Medicare Services Act of 2001 (HR3602)*, and Representative Upton (R-MI) joined him as the lead cosponsor. ACNM held its annual meeting in DC that year, and 600 midwives stormed the Hill to lobby for support of their Medicare equity bill. The College was hopeful that this might be the Congress to pass their legislation. But everything changed politically on September 11th when terrorist-hijacked planes bombed the Pentagon and brought down the twin towers. A month later the US

went to war, and all subsequent political efforts centered on recovery from the attacks, defense efforts and homeland security. Senator Conrad never introduced the companion bill, and the 107th Congress ended with no action on the midwife reimbursement bill. MW08 recalled the frustration of that time:

And we just worked painlessly hard and we got nowhere. That's what I remember most in those early years. The House was controlled by the Republicans, and we just got nowhere. We had no cosponsors, and we couldn't even get the previous year's cosponsors to sign on again.

In 2003 the 108th Congress began with Republicans controlling both the House and Senate. With the 9-11 attacks 16 months in the past, President Bush began promoting his health agenda which included a prescription drug plan for seniors. ACNM hoped that the effort would be a potential vehicle for their bill. Representative Towns introduced the midwife bill with yet another new name, the *Medicare Payment Update for Certified Nurse-Midwives Act (HR2980)*, and this time midwives chose to advise their sponsor to simplify the bill by leaving out the birth center reimbursement piece. At the annual meeting in 2003 members pledged \$26,000 to hire a CNM intern to work full time on grass roots advocacy for six months. MW14 had envisioned the internship and explained how it unfolded:

So I remember... several times trying with full force effort to go forward... and getting nowhere. The last time was out west somewhere and I had said to (the executive director), "So we need \$10,000, and so we're just going to raise \$10,000. We're just going to challenge every state." And then she gave me a

look and I said "Well wait a minute, am I overstepping my boundaries here?" And she said "Well, no. But if anyone else told me they were going to do this then I wouldn't have believed them that they could make it happen." So we did the challenge at the last night, and we did raise the money, and... a student on the PEAC committee at that time took the job to be in Washington for that summer.

The midwife intern came to the national office in the summer of 2003 to work on promoting enough bipartisan cosponsors that there would be a chance to move the bill. By the end of the first session of the 108th Congress the Medicare equity bill had its largest ever number of cosponsors. MW09 recalls her six months in Washington:

So I had a ton of energy, and a little bit of inner perspective and I just really felt like the personal connection is really important here. And then I felt organized... no one had really put the grassroots piece together. So I took over all the Republicans on the Ways and Means and the Energy and Commerce Committees. I think we hadn't really moved onto the Senate Finance yet, but I dabbled with that a little. But mostly my focus was really on the House, and just tried to get as many people as possible on the bill. And we got some real unexpected people. And I feel like we had more cosponsors that we had ever had before from both sides of the aisle. Of course, it was a different climate then... But doing a lot of education with a lot of Republicans who eventually I

think – because more people who were less polarized were willing to come on – so I think eventually we got something that was not Democratic heavy.

Unfortunately the intern's efforts were not sufficient to move the bill, and before the year ended President Bush signed the *Medicare Modernization Act* with the new prescription drug plan into law without the CNM Medicare reimbursement provision. MW14 talks about the lessons learned from that six month experiment:

And I think that that was when we learned that we has several big obstacles, And that we were going to have to really refocus and do it a whole different way than it had ever been done before. And it wasn't going to get tacked on to some other bill – we were going to have to baby sit it, like it was a new born, every single day.

In 2004 ACNM decided to make some changes in how it conducted its legislative efforts, and hired an established Washington lobby firm to direct and implement its policy initiatives. The PAC efforts were refocused locally, and the membership was educated on the process for endorsing political candidates. Senator Conrad introduced the *Improving Access to Nurse-Midwife Care Act of 2004* (S2492). As the 108th Congress came to a close, the new lobbyist advised ACNM that the 95% message was confusing Members of Congress, and encouraged them to reconsider advocating for “equal pay for equal work”. MW02 what happened that year:

And then I think I came back on board around 2004, or around then, and at that time we started to look at the bill again trying to determine what should

this bill look like going forward, what should we be doing going forward. And I talked to the Board about modifying the bill, taking out some of the extra provisions, moving those separately, and having the bill just be stand-alone looking at the reimbursement provision, and modifying it so it would be 100 percent. Now the argument in the past had been that 98% was achievable looking at the costs of midwifery practices and in comparison to physician practices and then in comparison to nurse practitioner practices... So I thought what made a lot more sense, and what would be clearer to everyone – members and the Hill, is total equity. And if you look across other health professionals that bill under the Medicare program, there are lots of examples of other non-physicians receiving 100% for the codes they bill that a physician might also bill. So at a point in time there... the Board decided to vote to do that, to condense the bill to this one provision along with the CM provision which was maintained and to fight for 100 percent.

The 2005 109th Congress could have been a turning point for the midwife legislation. Representative Towns and Senator Conrad introduced the *Improving Access to Nurse-Midwife Care Act of 2005* (HR872/S911) early in the first session. This time the bill contained a provision for 100% reimbursement for CNMs/CMs, along with the provision to pay midwives for resident supervision. ACNM once again held their annual meeting in DC, and 500 midwives visited over 300 Members of Congress asking them to support Medicare equity for midwives. But on the morning of their Lobby Day, the American College of Obstetricians and Gynecologists (ACOG)

sent a letter to legislators expressing serious concerns about the midwife bill and asking Congress not to move it forward, and to instead take up a Medicare payment issue that impacted physicians. MW08 remembered the disappointment of that day:

The Annual Meeting was in DC that year, and I remember... I really felt like people understood the importance of legislative action, and we were all really charged to go to the Hill... And I remember that evening we had a PAC reception after the day on the Hill... and while we're there (the lobbyist) comes over and whispers in my ear and says "You're not going to believe this but today ACOG came out against our bill."

ACNM immediately responded to the ACOG letter citing outstanding CNM outcomes that were "at least comparable to OBGyns", and sharing the negligible cost estimate for the CNM Medicare bill that had been calculated by the Congressional Budget Office. Midwives continued with an aggressive grassroots campaign, and 23 national nursing organizations came out in support of the midwife bill. As the first session drew to a close, Senator Conrad began looking for the right vehicle for attaching the CNM Medicare equity bill, and the College intensified its efforts. A new monthly legislative publication in January 2006 gave members access to more up to date news on bill efforts, and August was planned as Lobby Month. ACNM was hearing that the annual Medicare payment readjustment for physicians was being discussed, and had hoped to attach the CNM Medicare reimbursement to that effort, but campaign requirements cut short the session and the 109th Congress closed without any progress on the midwife Medicare equity bill.

The 110th Congress brought significant changes in the composition of the House and Senate. The 2006 elections had given Democrats a solid majority in the House, and the Senate was split evenly between the parties. House Democrats were planning a State Children's Health Insurance Program (SCHIP) reauthorization bill that would also include a number of Medicare provisions. The Government Affairs Committee mobilized midwives in all six regions to promote the Equity bill in hopes of having it included in SCHIP legislation. The *Children's Health and Medicare Protection Act of 2007 (HR3162)* passed the House with the midwife reimbursement piece included, and the College celebrated this first legislative success. MW08 recalls this bittersweet moment:

And then... I remember when we finally got the bill passed in the House as part of the CHAMP Act. And that was really exciting because we'd never gotten it passed through a chamber before. And that was, I remember Nance Pelosi, and it was just again a major milestone. We knew it wasn't going to go through the Senate at all, but I just felt like that was such a huge exciting time. I remember that conference call with (the lobbyist) and we were so defeated but also excited, and (he) was really trying to give us a big pat on the back "We did a good job and thank you".

Unfortunately the Senate was not as successful in moving comprehensive legislation that addressed both SCHIP and Medicare provisions. Instead they passed a stand-alone SCHIP reauthorization bill, which did not include any Medicare provisions. Next the Senate passed a Medicare vehicle, and in conference with the House pushed

to have the House midwife provision reduced to 85%. ACNM rejected this proposal, and the final Medicare package passed as a stripped down bill that did not include the midwife provision. MW03 remembers that fateful decision to hold out for 100%:

And my memory is that it was getting close to Christmas time and so I got a call from (the lobbyist) at that time asking, saying he was getting a lot of pressure to go to 85% from 100. And we talked a lot about, you know we'd been using the MEDPAC recommendations, and we've been kind of telling half of the MEDPAC recommendations but not the whole story. I remember basically I called through the leadership of the Board to see what were we going to take, were we going to go ahead and take the 85%, or were we going to hold out for 100. And we were arguing about, not arguing but debating it here on staff, and that I found very interesting that obviously for the most part people really didn't want to accept the 85% and felt really insulted by it in a way that was very personal and visceral. Whereas I kind of saw it more as just deal making. But I remember having one of those out of body experiences where you know, where you are looking out, I guess it was probably dark, it was probably night, but just that feeling that you are making a really big decision and you are not sure whether you are going to make the right decision or not... You know, obviously we decided not to take the 85%, and that – you know, I think our fates were always hooked up with the NPs, and that once we got into their bucket with them, we weren't going to go anywhere. And so we drew the line on that.

It was a huge blow to midwives who had thought they were finally at the finish line. ACNM was beginning to suffer burn out after working so hard on the bill for over two years. But with a critical election on the horizon, ACNM began encouraging its members to get educated about the candidates and involved in the election. The results of that election opened the window of opportunity that midwives had been waiting for. The 111th Congress began with a strong Democrat majority in both chambers of Congress, and a new Democrat President with an aggressive health reform agenda.

The entire nursing community was energized at the opportunities available through comprehensive health reform. ACNM joined a coalition of all the major nursing groups that was developing a nursing agenda for health reform, and the coalition included the midwife Medicare equity bill in their platform. ACNM was also collaborating with ACOG to promote a women's health home as part of health reform legislation. Both midwives and ObGyns had been excluded from the list of providers being considered for a medical home provision in health reform and ACOG was grateful to have an ally in their effort. In return ACOG, for the first time, gave its full support to the midwife Medicare legislation. Members worked tirelessly to get cosponsors for the *Midwifery Care Access and Reimbursement Equity Act of 2009 (HR1101/S662)* which had been simplified again by removing the provision to pay nurse-midwives for resident supervision. As the health reform debate heated up, the House and Senate both introduced bills that contained, among their many provisions, 100% equity for certified nurse-midwives. MW08 lauded Conrad's staff

for keeping the issue before him, and described the Senate deliberations to include midwife Medicare equity:

And then I'll never forget when it got attached to the Health Care Reform bill... the night that Kent Conrad from North Dakota brought up our bill to Senate Finance. I was lecturing to... nurse-midwifery students and I had my cell phone sitting next to me because (the lobbyist) was texting me back and forth like "they're going to bring it up"... And then it was late at night, and I didn't listen to it live cause I was lecturing, but (he) was sending me a little streamline on CNN. And I remember hearing Senator Conrad saying 'Well I don't know if you have any nurse-midwives in... but I'd like to bring up the provision that...' And I remember it being a very exciting moment... then (he) called me and said "We're in – it got included."

Although both *HR1101* and *S662* contained language that gave 100% Medicare reimbursement to both certified nurse-midwives and certified midwives, a last minute compromise because of pressure from policymakers excluded the certified midwives from the legislation. MW12 discussed her frustration with that concession by ACNM:

And where I thought the pressure point was, was to exclude that particular element from the law, since it was in there from early on, and in there for quite a while, and all of a sudden it was no longer acceptable... It would be interesting to know what was the impetus behind that... And it is what were you not willing to give up, what will you not compromise on? And that's why

the decision was made by the college that we will fight for the 100 percent, and it may take longer but we will get the 100% and will not compromise on that and take less and get it done sooner. And that was one of the reasons why I always wondered what got the CM's taken out. To me it's almost a lack of will. We had a will to get the 100%. We didn't seem to have a will to keep the CM's in.

On October 8, 2009 the House of Representatives passed *HR 3590, The Patient Protection and Affordable Care Act*, which contained the midwife Medicare 100% payment language. The Senate took up the bill and amended it by replacing the House language with a combination of the two Senate health reform bills. The amended *Patient Protection and Affordable Care Act*, which also contained the midwife Medicare language, passed the Senate on December 24, 2009. MW13 described that year:

When I was first on the Board one of the things that happened... (the GAC Chair) suggested that any time ACNM Board members were in town for meetings that we should come a little earlier and also go lobby our Congress people... And so we were doing that during that year that health reform got introduced and passed. But I remember... we were in one of the congressional offices and we were going to meet with somebody, and we were sitting there and having a cup of coffee and talking. And you know the famous song "At Last" came into my mind.

The battle to pass health reform was not yet over. Teddy Kennedy's death on August 29th, 2009 had set up a special election to fill the Massachusetts vacancy. With the unexpected election of Republican Scott Brown to fill Kennedy's seat on January 19th 2010, the precarious majority needed to pass legislation in the Senate was lost. This put the potential to successfully come to agreement on a compromise between the House and Senate bills into grave jeopardy. MW03 describes her feelings after Scott Brown's election:

So just remembering the drama, again it was around Christmas time, when the House passed it, and then in January we thought it was a slam dunk, that the Senate was going to pass it. And then Ted Kennedy died, and that Scott Brown got elected. And again I remember, being in this office and I the next morning, looking out, and the city just didn't feel like the same city any more. Like this hush had gone over the entire city. Because I have this interesting vantage point. I feel like I see the whole city from here. And I was like, everyone is grappling with this disaster. It was like a soap opera the way it was turning. You know, that you were so close, and all of a sudden it was so screwed up.

Two months of very contentious debates between House and Senate Democrats resulted in a compromise. On March 21, 2010 the House passed the Senate amended version of the *Patient Protection and Affordable Care Act* which was signed by the President on March 23 as *Public Law 111-148*. A second bill amending some of the Senate added provisions, the *Health Care and Education Reconciliation Act of 2010*, was passed by the House and Senate, and became *Public Law 111-152*.

After 19 years, Medicare equity was a reality for nurse-midwives. MW08 described the celebration at the ACNM annual meeting in Washington that June:

So we're in DC for the Annual Meeting in 2010, and it's after the bill had been signed into law... And (the ACNM President) and I were talking about how we could really take a moment, so the membership could take a moment and really recognize that we finally got this bill passed. And so during one of the general sessions when all of the ACNM members were there, we had an African American midwife named Carolyn something, I can't remember her name, I think she's from Minnesota. But (the ACNM President) was friends with her, and so (she) was at the podium, I can't remember what she was talking about. But she was saying "I have a surprise for you tonight and this is our gift to you." She didn't say anything about what it was. And then Carolyn went up to the mike and with this big beautiful African American voice sang this song from Etta James, "At Last". And we had rewritten the words to be about the Medicare bill. It was so exciting. I mean we all were just sobbing and sobbing. Just thinking about it now I have chills. And it was such a big hit that she sang it again at the closing party. It was just really very cool.

Thematic Analysis of Interviews

The thematic analysis of interviews discusses categories, themes and subthemes that were identified from the 14 midwife interviews. The chart below summarizes the 6 categories, 19 themes and 29 subthemes that will be discussed.

Table 3: Midwife Themes

Categories	Themes	Subthemes
<p>Policy Agenda (problems and solutions) 26 Codes 70 Quotations</p>	<p>1. Midwife Initial Inclusion in Medicare</p> <p>2. Components of the Medicare bill</p> <p>3. Cost of Medicare equity bill</p> <p>4. Enactment of bill and beyond</p>	<p>a. Why 65% to begin with b. Why 65% didn't work</p> <p>a. Changing provisions and titles b. Confusing rationale for reimbursement percentages</p>
<p>Politics and the Political Process 47 Codes 93 Quotations</p>	<p>5. The political process</p> <p>6. What it takes to pass a bill</p> <p>7. Politics</p> <p>8. Political Porters</p> <p>9. Emotions experienced during the process</p>	<p>a. How the legislative process works b. How long the process takes c. Congressional impact on the process</p> <p>a. Importance of a vehicle b. Importance of timing c. Importance of cost analysis and scoring</p> <p>a. Party Politics b. Political Climate</p> <p>a. Importance of choosing the right sponsors b. Political connections</p>

Categories	Themes	Subthemes
Midwife Relationships 19 Codes 46 Quotations	10. Relationships with nursing 11. Relationships with physicians	
Midwife Organizational Capacity 72 Codes 193 Quotations	12. Organizational Resources 13. Organizational Leadership and Management 14. Individual and collective midwives	a. Small size of the organization b. Amount of money for political advocacy a. National office issues b. Lobbyist effectiveness c. Elected leadership of the College d. Contributions of volunteer leadership a. Personal characteristics that impact political advocacy b. How midwives are perceived / branding
Midwife Political Competency 41 Codes 135 Quotations	15. Organizational Strengths 16. Organizational Weaknesses	a. Persistent laser focus on issue b. Engaging members and leadership in grassroots political advocacy c. Evolving political sophistication a. Inconsistent and inadequate strategy development b. Poor messaging of decisions, issues and accomplishments c. Inadequate coalition building d. Not enough DC presence

<i>Categories</i>	<i>Themes</i>	<i>Subthemes</i>
Gender Issues 21 Codes 42 Quotations	17. Gender impacts political capabilities 18. Gender impacts political reception 19. Gender of the care recipients	

Policy Agenda

The first category of codes identified was Policy Agenda, and referred specifically to the problems surrounding Medicare reimbursement for midwives and the possible solutions to address those problems. The category Policy Agenda includes the many iterations of the midwife Medicare equity legislation, and the original legislation that established coverage of midwives under Medicare when it was included in OBRA 1987. All participants in the midwife case spoke about Policy Agenda issues, and four major themes emerged in this category: *midwife initial inclusion in Medicare, components of the Medicare equity bill, cost of the Medicare equity bill*, and *enactment of the Medicare equity bill*.

When OBRA 1987 passed with the midwife Medicare direct reimbursement language included, it set up an inequitable reimbursement schedule that had far reaching implications for midwives, and from that point they sought a policy solution to the problem. Seven midwife case interviewees spoke about the *midwife initial inclusion in Medicare*. Two subthemes became evident in this theme: *why*

65% to begin with and why 65% didn't work. MW14 spoke about why she thought the initial Medicare reimbursement had passed with 65%:

So I think that when the Medicare went through at 65%... The message to us was that it was a backroom deal and it was cut at the 11th and a half hour after everyone had left that would have protected that from not happening. And it was certainly orchestrated by traditional medicine saying that that was a fair percentage.

At first some midwives thought that 65% was better than nothing, but soon it became evident that 65% would not be sustainable. MW05 talked about what the 65% meant for midwives.

I think you had to have someone in there who was a nurse midwife who understood what this was going to mean. It would mean the death of midwifery. It was just not sustainable getting those low reimbursement rates. Because, as managed care came in they said, "Oh you only get this much? That's what we're going to give you." It's not sustainable.

MW02 described how that reimbursement differential had remained a significant problem over the years.

But I think in the past that reimbursement differential was such a problem that not only was it Medicare but also pervades Medicaid, only about half of the states are paying at 100%, and it pervades private pay. So if you are always at such a disadvantaged differential then how do you catch up, how do you open a private practice? How do you open a free standing birth center?

The largest theme in the Policy Agenda Category was the ***components of the Medicare equity bill***. All but one of the midwife case contributors spoke about this theme, and two subthemes were discussed as having contributed to the difficulties in moving the Medicare equity bill: *changing provisions and titles*, and *confusing rationale for reimbursement percentages*.

Many of the respondents felt that the *changing provisions and titles* of the bill had been a problem in effectively moving the bill. The final Medicare equity that passed as part of the Affordable Care Act in 2010 contained only one provision – 100% Medicare reimbursement for nurse-midwives. However over the 19 years of the Medicare equity quest the bill had contained a number of other provisions, including a bonus for working in health professional shortage areas (HPSA's), birth center payment, resident supervision payment for nurse-midwives, and payment of CMs under Medicare. MW08 noted:

You know it used to have a birth center provision. That got taken out. There used to be CMs included, that got taken out. I think as it slowly got stripped down there was more support. So I think those decisions that were made by ACNM to just keep it really clean and simple...

Additionally, there were six different titles of the Medicare equity bill beginning with the *Primary Care Health Practitioner Incentive Act* that included NPs and CNSs. The stand-alone midwife bill that followed went through five name changes: the *Certified Nurse Midwife Medicare Services Act*, the *Promoting Access to Medicare Midwifery Services Act*, the *Medicare Payment Update for Certified Nurse-Midwives*

Act, the Improving Access to Nurse-Midwife Care Act, and the Midwifery Care Access and Reimbursement Equity Act. MW01 saw this as a problem:

We kept changing the name of the bill, and looking back, I don't know if that was a good idea in all honesty. I have mixed feelings about that, when you have been doing it for so many years.

Another problem with the bill was that the changing payment levels over the years, and the *confusing rationale for reimbursement percentages*. It started with 97% in the first bill with NPs, then the NPs and CNSs passed their bill at 85%. The first midwife stand-alone bill was at 95%, and finally the bill asked for 100% which was how it eventually passed. A few of the midwives who were interviewed saw this as very confusing, and were not really sure how many different percentages there had been, as evidenced by this quote from MW04:

I think that it is a really hard line to walk, when you are trying to sell yourself as cost effective, and particularly where things were towards the end with the Affordable Care Act, you know, you are trying to develop an argument that is going to sell. And clearly a 35% reduction in the cost of your services is pretty easy to argue against. But why shouldn't you take 85%, or 95% or 90% - or how many values did we have - 97%? I had totally forgotten about that - now there's a problem - what did we really want - 90, 95, 97? What's the rationale for all of these?

And finally, the real problem with the changing percentages was that the rationale for each different level muddled the true argument for equal pay for equal work.

MW08 described when she began to understand that argument:

And I remember (the lobbyist) was like "It's an equitable service and you guys need to ask for equitable reimbursement. That is not a talking point to say that our malpractice is less than theirs so we should ask for less than them. It's the same service and if we're going to make this argument you have to change it to 100%." And that felt like such a right decision. And it changed our talking points. And I think it made us feel more confident - like we are asking for something that we deserve. This is how it should be.

There were two other much smaller themes in the Policy Agenda Category.

The first was the ***cost of the Medicare equity bill***, which is exemplified by these two quotes from MW10 who spoke about the early cost analysis of the bill:

Well for one they found out the cost would be essentially pennies because we do not see a large number of Medicare women and at that point in time we were only "authorized" to do pregnancies, not doing well women or gyn.

And then later MW10 talked about how the cost of the bill impacted its final inclusion in health reform legislation:

And I think that because the budgetary under pinning of what we were asking for were so small that it was not really seen as an issue.

The second was ***enactment of the Medicare equity bill***, which had to do with frustrations that the battle wasn't really over and that 100% reimbursement might not actually be a 100% win. MW12 reflected:

Any of us who have been involved with legislation know that it is fine to get it into the law, but then you have to either enforce it in the law or you have to see what laws exist that countermand what just was passed. Now you have to clean up other bills to make it work. And so it is always a much more long and tedious process than we thought.

Politics and the Political Process

The second category of codes takes into account politics and the political climate shaping the landscape around the midwife Medicare equity quest, as well as the specific legislative processes that impacted the different iterations of the bill over its 19 year time. All fourteen participants in the midwife case spoke about Politics and the Political Process, and four main themes were identified in this category: ***the political process, what it takes to pass a bill, politics, and political porters***. One minor theme also became evident: the ***emotions experienced during the process***.

The political process specifically ponders the legislative processes that lead to an issue becoming a bill and the progress of that bill through a legislative body. Ten of those interviewed for the midwife case spoke about ***the political process***,

from which three subthemes were identified: *how the legislative process works, how long the process takes, and congressional impact on the process.*

The participants spoke about how the protracted effort to pass Medicare equity was impacted by *how the legislative process works*. Some of the participants described this process as obstructive; others merely thought it was mysterious. For most of them it was a frustrating process. MW11 talked about her views of the legislative process:

And I honestly don't know what the strategy is to get a bill brought forward... what it would take to do it to me is one of the mysteries of the legislative process. Why some things come up and others don't... So to what extent there was effort to block bills from coming forward that just happened to have our Medicare bill in them I don't know. I never got the sense that there was any deliberate effort to not take action on it. But it seemed to be part of a political dynamic that in my perspective was somewhat mysterious.

A second subtheme had to do with *how long the process takes*. Participants talked about not being able to move the bill and not being able to push it over the edge. They believed that issues need to ferment in Congress, and that sometimes it felt like an ongoing saga with no resolution. MW03 described the slowness of the political process in this way:

My theory, because of my previous experience of how hard it is to get things done, so I don't know the legislative history of what we were trying to attach it to, but my sense is that it takes a really long time to get things done.

The third subtheme identified was *congressional impact on the process*. This included congressional priorities and turnover, the pecking order in congress, and congressional saturation with the issue. And as MW12 shared, sometimes congress just does the right thing:

I would love to believe that the legislators saw that as something necessary and meaningful for the citizenry of the country. I don't think they care. But I think some of them might have had pressure from constituents to do the right thing in some regards. So I think that helped, whether it was crucially important or essential for it to pass, I don't know. But it seems like it should've had a positive impact.

The second theme identified in the Politics and the Political Process category was ***what it takes to pass a bill***. All but one midwife case participant discussed this theme, and two major subthemes and one minor subtheme become apparent: the *importance of a vehicle*, the *importance of timing*, and the *importance of cost analysis and scoring*.

There was a very strong consensus among all those interviewed that having the right vehicle is critical to passing a small piece of legislation like the midwife Medicare equity bill. MW07 talked about the *importance of a vehicle*:

And what we ultimately learned was that we needed the vehicle. And I think having the vehicle which as you know... And we're talking about the 100% reimbursement, and we got where we always, for several years, we had sponsors who were loyal to us for whatever reason. And all the work that was

done to keep that going. But it ended up that as a lone bill it wasn't ever going to make it through the system. So getting the right vehicle.

Another strong consensus was the *importance of timing* in moving a piece of legislation. MW06 talked about how everything came together during the time of health reform:

I think that the change in the legislature made a huge difference. In 2008 I was riding high. Having the Democrats be in power of everything was like "ah this is the time where we can really get stuff done". And that's why it got done then. I think because the legislators had heard from us over the years may have helped. I think it was just the right time, I think it was the perfect storm.

Only three midwife case participants spoke about *the importance of cost analysis and scoring*, but it also emerged as a subtheme in the NP case. MW06 described how CBO scoring impacted the process:

And we could never get the right CBO score; we were always waiting for the score. So year after year we did our visits and nothing happened.

Eleven midwife case participants spoke about the third theme identified in the Politics and Political Process category. **Politics** refers to the principles, opinions, methods and maneuvers surrounding the political process, and two subthemes were identified: *party politics* and *political climate*.

The participants who spoke about *party politics* believed that it played a role in the effort to move the Medicare equity bill. They noted that changes in party control means changes in congressional leadership, and whoever is in control of a

congressional body also controls that body's legislative agenda. Similarly, they noted that whatever party controls the White House gets to set the Presidential agenda.

MW08 explained why these things are important:

And then I think another reason was that whenever the Republicans were in control of the House we just didn't have a lot of...(pauses to think)... it was so lopsided always in terms of bipartisan support. So when the Republicans were in control we just never got anywhere.

The participants also believed that an individual or group that works well with both parties has a better chance of garnering bipartisan support for their legislation. The ability to appear non-partisan was a very stark difference between the two ACNM lobbyists, as MW07 explains:

(The first lobbyist) was definitely seen as a Democrat. But I don't think I could tell you to this day whether (the current lobbyist) was a Democrat or a Republican. He has always left his political beliefs out of the conversation. And he was probably one of the people who told me we had to get away from that reputation.

The second subtheme identified under **politics** was the *political climate*. The individuals who spoke about *political climate* believed that a changing political climate was responsible for the ultimate success of the Medicare equity effort. They defined this climate in terms of how policymakers viewed the rising costs of health care, and in particular, the cost of maternity care in this country, and discussed how

this was changing the longstanding political focus on a traditional medical paradigm.

MW05 described it in this way:

I think that it took off and passed for a whole lot of reasons. I think the climate changed in the country... I think what happened was that the congress of the United States was starting to understand that the trajectory of health care expenses was off the wall... They realized they couldn't sustain it and were finally looking for other ways... I think ANA came in with nurse practitioners and they were starting to understand that nurses could (be) more than just people who dressed up in white uniforms and that just dressing people up in white uniforms didn't make them nurses. Finally they got that. I think all those things started to roll around in the psyche of the people who worked on the hill. They finally started to get it.

The fourth theme identified in the Politics and Political Process category was **political porters**. Five of the interviewees spoke about **political porters**, and there were two subthemes identified. The interviewees believed that *political connections* were critical in being able to move a piece of legislation, and spoke about the *importance of choosing the right sponsors* and supporting those sponsors. MW02 questioned whether the choice of one sponsor was having an impact on moving the bill:

So those are my initial thoughts - that at the time, Mr. Towns might not have been the member that I would have chosen. But we worked with it, and we were lucky that we had an active group of New York midwives. And I

remember several opportunities that the midwives had either here in DC or up in New York to talk with him about this bill. And they were always very active, so that was good. It kept it on his radar. But, you know, you always wonder how hard they're really working these bills. And because I also knew that he was working on some other legislation, and I knew that he was not pushing those bills. I knew that specifically. There was a bill for athletic trainers that he would introduce every year, and I knew he wasn't working that.

Finally, there was one minor theme identified in the Politics and Political Process category. Five midwives talked about the ***emotions experienced during the process***. MW08 shared the incredible highs and lows she experienced while advocating for the bill:

And then I remember in 2005 it was a really big moment in DC when we were lobbying on the Hill. And it was such an exciting day... that evening we had a PAC reception after the day on the Hill, and it was such a popular thing and people were trying to go to the reception and people were hawking their tickets. It was such a big day... and while we're there Patrick comes over and whispers in my ear and says "You're not going to believe this but today ACOG came out against our bill." And it just completely deflated me from this huge high from the day and now like "ugh". Well, we had high moments and a lot of low moments, and that was just for me both ends of the spectrum.

Midwife Relationships

The next category of codes identified was Midwife Relationships, which covers other health professional special interest groups in the health care arena, their relationships to each other and to midwives. Twelve of the midwife case participants spoke about how relationships with other groups impacted ACNM's quest for Medicare equity. Two major themes emerged in this category:

relationships with nurses, and ***relationships with physicians***.

Nine of the individuals who were interviewed spoke about ACNM's ***relationships with nurses***. They noted that there is a certain amount of animosity towards nursing by some midwives and a strong desire to be independent from nursing. Part of this came from the conflict over who speaks for midwives, which MW07 explained has been a long and difficult negotiation:

For a while when the American Nurses Association began to speak about nurse practitioners and nurse-midwives we were not the only organization that had a strategy to stop that... and we said we would appreciate if the American Nurses Association would defer to us when they were in a position to speak about any profession besides basic nursing. And that was because there were policy statements coming out, and position papers, and we were misrepresented. And they were inaccurate. And... when Jan Trotter Betz wasn't president of ANA anymore, and she got a position within Health and Human Services, I would say it got more difficult because she was very well spoken, and she wanted nursing to speak for nurse-midwives.

However the participants also regretted the fact that there has been so much infighting in nursing over the years. They spoke about the size and political clout of ANA, and recognized that nursing unification during health reform was one of the reasons for the success of the Medicare equity effort. MW04 shared why this was important:

It seemed to me that with health system reform on the horizon, that the nursing community, and by that I mean the people with the letterhead, decided that the circular firing squad behavior was going to be even more dangerous than it had ever been. And that there was a need to link arms, and sing kumbaya, and go to the hill with a unified message of what nursing wanted from health system reform. And the fact that ACNM - and I don't even know who it was, whether it was (the lobbyist) who was going to those meetings, got that on the agenda and the nursing community got behind it - was incredibly important. It wasn't just ACNM looking for a vehicle to get this done. It was THE NURSING COMMUNITY, coming together to prioritize a set of issues. And my sense was that there wasn't any real significant push back to that being on the list. So it wasn't just the midwives and ACNM lobbying for this anymore, now it was a piece of the nursing community's lobbying.

Seven participants spoke about the second theme that was expressed in the Midwife Relationships category, ***relationships with physicians***. These participants spoke about how physician opposition had hurt midwives' political efforts over the years. MW10 shared these thoughts:

I think medicine really did not want to...(pauses to think)... they see this chipping away at their independence, autonomy and capturing their economic base. And because they have such a strong lobby that this was one of the big issues... And until an omnibus act actually came onto the table then they didn't have to oppose anything at all. But under the table there was speculation on our part, and I think it was valid, that AMA was undermining it. They were saying " why should midwives get paid to do this? They don't do what we do, they can never do what we do." So I think there was a lot of that going on.

Participants also recounted how recent collaborative efforts with ACOG had made it easier to pass the Medicare equity bill. MW13 shared how this was important to policymakers:

And having ACOG support this effort was important. I remember Conrad saying in that hearing when they voted to get it on the Affordable Care Act, I remember him talking about it and then he said "And ACOG supports this". We didn't have ACOG's support for a long time, but we did the last two times. And it helped.

Midwife Organizational Capacity

Midwife Organizational Capacity was identified as the fourth category of codes isolated in the interviews. Organizational capacity refers to the components of an organization that are critical to its effectiveness, and as used here encompassed the resources of the organization, its leadership and its membership.

All participants interviewed spoke about Midwife Organizational Capacity, and three main themes were identified in this category: ***organizational resources***, ***organizational leadership and management***, and ***individual and collective midwives***.

All 14 individuals in the midwife case spoke about ***organizational resources*** impacting the ability of ACNM to compete in the political arena. Two subthemes were identified in this discourse: the *small size of the organization* and the *amount of money for political advocacy*.

Despite the *small size of the organization* participants gave credit to ACNM for historically looking much bigger than its actual membership size. Some believed that at times the small size was an advantage because it made it hard for members to say no when directly recruited for advocacy. There was a strong consensus that the eventual legislative success was helped by midwives finally reaching a critical mass in this country, however MW05 talked about how the small size continues to impact the political clout of the organization:

It's going to be a long time still, to put midwifery on the map because we don't have enough of us and we can't have a large clump of people that we can look at that we have provided midwifery services to. It's not very big. It's very small and it doesn't hit the legislators as something really financially significant.

They can look at it and say "Oh, yeah that looks a little better than what doctors do but there's so few of you that, you know, you're not going to make an impact". So we kind of get pushed to the side.

Participants all agreed that the *amount of money for political advocacy* put ACNM at a disadvantage in the political arena. There were mixed feelings whether PAC dollars were critical to legislative success, but most noted that ACNM had never been a PAC power. MW12 spoke about her view of ACNM's PAC effort:

We certainly are not a powerful group, even with the PAC. We certainly don't stand at any high end of any PAC power, because we don't have the finances in that. And in my view, the political process in this country is very much predicated on who can finance the reelection of elected officials. And we certainly were able to garner some support over the years with some really good folk working on our behalf. But we were never able to have the necessary clout to get this done efficiently and effectively early on. We didn't fit into the system well, we don't have the power in dollars. And in my view our system is very much a dollar driven system.

MW02 summed up the **organizational resources** in this way:

And I think it's, you know, the Board has to make a determination of how far can they go. What resources do they have, what can they do?... But yeah, you can always do more. More with more. That's the challenges of every organization.

The second theme in the Midwife Organizational Capacity category and one that came up in all 14 interviews was **organizational leadership and management**. Everyone felt strongly that the people you hire or elect to represent you are integral to success in the political arena. Four subthemes surfaced from the

interviews: *national office issues, lobbyist effectiveness, the elected leadership of the College, and contributions of volunteer leadership.*

The participants held differing views on *national office issues*. Some thought that the ACNM staff was amazing, and that there was a strong team dynamic at the national office which supported political efforts. A few participants spoke about the dramatic changes in the national office in 2006, and how the resulting loss of institutional memory made it more difficult to be politically productive. But there was agreement that over the years the national office got better at political advocacy. MW05 shared this view:

I think as the years went by ACNM staff got really more sophisticated about how do you really do this. How do you really move legislation through congress? I think that was a slow process and I think we got better at that as time went by. We got better advice, we just got smarter.

Lobbyist effectiveness was another strong subtheme. Participants thought that the first lobbyist had connections and a style that helped in the early years of the policy effort. They also believed that switching lobbyists at the time they did was a growth decision for ACNM, and the choice to contract with a professional lobbying firm gave the issue better visibility. MW10 shared:

I think I saw a big change occur when we changed the structure and changed how we handled legislation on the national level. So when there was a change in the policy analyst and then the consulting arrangement with that group Patrick's with. That's when I saw a big change. And I don't know whether it was

because we were trying to do things internally and we were a little group and it was hard to get access to the players that can really make a difference, and thereby having a group that had the name recognition the broader base of influence than we had was important.

A few people talked about the *elected leadership of the College*, and felt that there had not been much policy leadership from early Presidents and BODs. And changing priorities due to changing leadership was also noted as a problem. MW07 reflected on how that might have impacted the process:

One could argue that as an organization we got distracted by lots of other agendas. I guess if I were to go back I would have my reservations about what we should or shouldn't have been doing. That's the life of an organization that has an elected board of directors.

Participants were very vocal about the *contributions of volunteer leadership*. Although there were some concerns expressed about PAC management, the committee members and Chairs of PEAC and GAC were seen as integral to the success of the legislation. MW09 praised the passion of the GAC committee:

And then the real force behind the bill is the volunteer Committee, I think. We were the ones who got the cosponsors on it, and that is why it was ultimately included in the vehicle in which it was included, because it had feet. And that was volunteer effort, because we care, because we're passionate and a little bit crazy. Absolutely it was the whole volunteer effort of members, but the committee is the one who holds the hands of the people as they go to the

telephone. We drag them to the telephone to call whoever it is, and get them on the phone again for the fourth time, every two years. But it is volunteer, it is passion I think.

The final theme that surfaced within Organizational Capacity was ***individual and collective midwives***. All 14 of the midwife case participants talked about the political impact of a membership consisting of midwives. Two subthemes were apparent in this theme: *personal characteristics that impact political advocacy*, and *how midwives are perceived / branding*.

The majority of participants talked about how midwives had some *personal characteristics that impact political advocacy*. They felt that the personality traits that make a good midwife are not necessarily traits suited to political advocacy. Midwives work long hard hours and do not always have time to be involved in advocacy. Additionally, many midwives do not work in independent practices and therefore do not see the importance of Medicare reimbursement practices. MW10 talked about how this has made advocacy more difficult over the years:

I think that ACNM did a great job of trying to educate the membership. I think the sad part is that the membership either didn't really understand it. And it was hard, and it's still hard for the membership to understand those reimbursement issues. I would say many midwives, the bulk of our profession, wants to be "give me my salary while I take care of my women, don't bore me with the details. I don't like this coding and billing stuff. I don't want to know about what all of this takes. Just tell me where I am supposed to sign so I can

get my provider ID numbers and let me take care of my women.” So while ACNM really did try and continues to try to educate the membership I think the way we are employed precludes us from learning it.

The second subtheme that was discussed in many interviews was *how midwives are perceived / branding*. Participants felt that people did not understand what a midwife was, they did not understand the difference between different types of midwives, and there was no perceived need for midwives as there was for nurse practitioners to do primary care. MW05 described why this made advocating for Medicare equity so difficult:

Because half the time every time you sat and talked to somebody about it from the hill, you would have to go... a nurse midwife means we're with women, and we're licensed, you know. You spend all this precious time you had with them explaining what a midwife was. And it's such a negative term in most people's minds. You didn't go in and say midwife and they lit up, they said Oh midwife, isn't there something wrong with those people. So I think the handle was really hard to walk around with that title. It got better over time. But that was a hard title, especially when I first started.

Midwife Political competency

The fifth category of codes identified was Midwife Political Competency. All fourteen participants spoke about political competency, and their responses encompassed all those things they thought ACNM did well, and all those things they

thought ACNM should have done better. There were two themes identified in this category: ***organizational strengths*** and ***organizational weaknesses***.

All of the individuals interviewed spoke about ***organizational strengths***, and there were three subthemes that participants thought were areas where ACNM excelled in their Medicare equity quest: *persistent laser focus on the issue, engaging members and leadership in grassroots political advocacy, and evolving political sophistication.*

The interviewees credited ACNM with continuing to work on the bill over the years even when they were getting no traction, and in keeping a *persistent laser focus on the issue* for their staff and membership. They spoke about constant evaluation of the efforts, setting goals for Medicare policy change, and trying multiple approaches to address the issue. Even during health reform when ACNM was being criticized for supporting the ACA they stayed the course to promote the Medicare equity. MW04 talked about her time at ACNM:

Well, I think that the message was pretty clear that it was a priority. And I am very sensitive to the fact that, on any one day, as the Director of Professional Services, your phone could ring and you could make a priority liability insurance. You know we have members going down the tubes with their tripling premiums. Education issues, there were so many issues that could have been a priority on any one day. And my sense from (the executive director) when I started working there was that this is the priority - we're going to get

this done. So I think that to establish it clearly as a priority - there was a lot of other noise in the room, but I do think it was established as a priority.

A second strength that participants identified was that the organization was doing a good job *engaging members and leadership in grassroots political advocacy*. ACNM invested time educating each new President and Board of Directors to fully understand the Medicare reimbursement issue. In later years the Board added a day on to each BOD meeting in order to lobby Congress. ACNM created educational materials for the members, held legislative conferences, and used annual meetings to educate and motivate the members. MW01 described the effort:

Because you know we did phenomenal training, every convention, major training just even on this one issue. We just kept building and building trying to get the members educated... I think the membership is much more educated on financing and is much more articulate to actually have these discussions, and understands the long-term relationships you need... I think too you'll still see, depending on the subject, that people really understand it. People understand that when we are talking about money, that we better be at the table. You can't be a player if you are not at the table. And I think we did that well.

The third subtheme of ***organizational strengths*** was ACNM's *evolving political sophistication*. Most of the participants felt that ACNM had been a reactionary organization in the early years of this legislative effort. However even then they understood the importance of tracking outcomes, and documenting

midwife practice. But as the organization matured they began to be more proactive. They hired a student CNM intern to work on the bill for six months. They updated the website and made it easier for members to get involved. They worked to grow a PAC and started holding annual meetings in DC every four to five years. MW07 described how the College matured over the years:

And obviously, one of the things that I do take pride in for the time that I was there was that I really feel we went from a very, very reactive organization - which that reflects how it really was in that you waited until you heard something and then responded - and then we really pushed an agenda to become more proactive. So then we were at the meetings, being invited to the conversation, being part of the development of new policies, rather than at the last minute finding out about them and begging them to listen to us. And I think we made a lot of inroads that way.

The other theme in the Organizational Political Competence category was ACNM's **organizational weaknesses**. Only nine of the participants spoke about specific weaknesses, but the four subthemes identified from their interviews all offer critical insight into areas that played a role in the long Medicare equity effort. These subthemes were: *inconsistent and inadequate strategy development, poor messaging of decisions, issues and accomplishments, inadequate coalition building, and not enough DC presence.*

Some participants believed that ACNM suffered from *inconsistent and inadequate strategy development*. There were so many big issues to be addressed,

and national office staff was frequently distracted by the day to day crises of midwives in the states. Interviewees spoke of missed opportunities, and ideas that went nowhere. And to some it seemed that there was never a clearly articulated strategy, as MW04 laments:

My overarching memory when I think about it was, that I always had a hard time getting my head around the issue, and the strategy. No, I shouldn't say the issue, I understood the issue, I had a hard time getting my head around the strategy. My memory was, from my perspective, there was never any clear strategy. And I spent an increasing amount of time, as I became more sophisticated, from a policy and association standpoint, trying to figure out if it was my lack of understanding about the process, or we didn't have a clearly articulated strategy.

In some opinions, ACNM suffered from *poor messaging of decisions, issues and accomplishments*. They never had quite the right messages about the provisions and percentages in the bill, and why they changed from year to year. They were not able to translate things the organization accomplished into a message that could build membership support and numbers. And they were never quite able to explain to nurses why they had chosen to step away from the 85% with NPs. NP04 explained this weakness:

Sometimes I think that, and this is true of a lot of what midwifery does as a profession, we make the right decision, we just message it very poorly. We have a hard time - we have made this decision and this is what we are going to do -

and instead of saying “well, we have considered all of our options and we have decided that this is the most effective way for us to move this forward - let us share with you our rationale and maybe we can bring you on board to move that direction with us”. That is not what we do. We say “this is what we decided to do and screw you and we don’t care what you think and we’re going to move on”. So I think that from my memory and my sense of what happens now when you talk about 85% vs 100%, and you look at sort of moving forward as an APRN community, I think we made the right decision, we just messaged it very poorly. You know, we’re the midwives; we go off and do our own thing.

The third subtheme under **organizational weaknesses** was *inadequate coalition building*. A few participants talked about ACNM’s weakness in not forming alliances with nursing and NPs during the middle years of the effort. And others spoke about ACNM’s failure to harness the potential of their consumers. MW02 described it this way:

I don't think the nurse-midwives were using their constituents which was very controversial too. The chiropractor's during health care reform - I loved them - they developed a video and they scheduled their appointment so you would have to sit in their reception area 10 minutes before you would see the chiropractor and you'd have to see this video. And then there would be the petition there to sign. And there would be talking points there to take home to call your congressional person. (The Director of Professional Services) was trying to put together the consumer group to really do that on a smaller scale.

And the Board was like, that was really controversial - you know we can't mix our practice with our consumers. And so we lost some strength there, we really lost consumer strength.

Finally, there were a few interviewees who spoke about the fact that within the ACNM membership and leadership that there is *not enough DC presence*. MW06 shared her frustration with this over the years:

The other thing I did not say is that one thing that has held us back is that we are not in DC enough. As a PEAC member, as a GAC Chair, as a Board member I have continually pushed to have us meet here in DC more often. Once in every four years is not enough. So the DC meetings are the best attended, yet they talk about how much it costs, and we can't do it because of how much it costs.

And MW08 talked about her efforts to impact this weakness:

I remember writing this Board agenda item when I was Chair to set aside some money for this sort of readiness action team. The deal was that if it was crunch time and we needed to get some legislator to sign on to a bill, then we had money to fly that midwife from in state to DC. It didn't pass because the money wasn't there, but I think we could do a better job of having more of a presence in DC. Like I know the PTs meet in DC every year, and I know that many professional organizations do that. ACOG has these fellows, and there's money set aside.

Gender Issues

The final category of codes is one that cross cuts several of the other categories, but it is included as a separate category to highlight its themes. Gender Issues is a category that every participant spoke about specifically because there was an interview question about the impact of gender. When I originally included that question I believed that it was singular in nature, but during the interviews three themes of gender emerged: *gender impacts political capabilities*, *gender impacts political reception/acceptance*, and *gender of the care recipients*.

Nine of the individuals interviewed spoke about whether *gender impacts political capabilities*. Three of the participants believed that women make just as good political advocates men, that women are smarter than men, and that being female gave them an edge on conveying their message. It was interesting to note that one of the three individuals who thought this was a man, and the other two were significantly younger than the rest of the interviewees. MW09 explained why she saw women as strong political advocates:

Because our bill means that we can stay in practice and help even more women.

So in a way it was about money, but mostly it was about heartstrings. And I think it is possible that women can sort of convey that message a little more.

But I think women are more drawn to that sort of caring and nurturing that is not really new information.

The other six participants believed that women are not inherently drawn to political advocacy, and that they needed to learn the role. This is how an MW03 described women's abilities as political advocates:

But they don't, a lot of them don't have any real affinity for politics, and they don't really like politics. They don't really like the PAC, they see it as bribery. And they're really disgusted by that aspect of politics. So they don't really, they aren't - my other organization was really male dominated. And they loved getting in there and fighting. I never heard some of the comments I've heard at ACNM about the process, and how repellant it is. In 15 years I never heard anyone say any of those things. So I think we've had to kind of get over, suck that up and learn how to engage. But I think there's a good portion of the membership that really doesn't want to have anything to do with it.

Eleven of the participants shared thoughts about **gender and political reception/acceptance**. Once again, the two younger participants thought that women are better accepted by young legislative staff, and that the stereotype of being a midwife was more of a barrier than being a woman. MW09 put it this way:

I think it's possible because legislative assistants are usually youngish, and usually fresh out of school, that women can sometimes connect with them a little bit better... I think a woman might be more likely to get under the skin of a legislative assistant, and sort of bring them around to this issue.

The other nine participants thought that women are not taken as seriously by policymakers. More importantly, several expressed the belief that women are

disadvantaged because they do not have access to the 19th hole. MW10 explained what this means, and why having a male lobbyist made such a difference:

I think the fact that we have somebody who is a “good old boy” - I’m sorry but I’m from the south, and that makes a difference. I don’t care what anybody says, but I would love nothing more than to have access to what we call the 19th hole. The 19th hole is after you’re done with your 18 holes of golf, the men go into the locker room and they have a “good old boys” session. And it may not be that anything is determined at that time, but you learn about each other and you become the goombas, for lack of a better word. And if you need a favor you call another goomba, and you have had that 19th hole camaraderie. I don’t have access to the 19th hole. I’m not worried about deals going down in that locker room. But now they’ve got that social network. And women, we’re not at those tables. So we don’t have that social network.

Nine of those interviewed believed that the ***gender of the care recipients*** played a role in how long it took for midwives to achieve Medicare equity. The two younger participants did not weigh in on this, and all who spoke about it believed that women’s issues do not matter as much to policy makers, and that policymakers don’t want to deal with anything that has to do with women’s health because that is such a charged issue. They noted there is a constant struggle in Congress to protect women’s health. MW12 shared her impressions of how women’s issues are viewed in Congress:

You know the constant-ness of the attacks on women, be it contraception resources available, or anti-abortion laws being passed. There's a constant struggle in the legislature staving off people who just seem to pick on women and their ability to have access to critical health care services... Maybe not directly because of gender but there is something in there that women are still second class citizens in my view and the minds of many of the congressional folk. And they don't know enough to make the right laws so we'll do it for them and we'll do it our way. I mean I go back all the time to, look how long it took to get contraceptive services available to women as part of their healthcare benefits in a health care organization. And yet Viagra was in there free to men basically right after it passed the FDA. Wait a second; does nobody see any problem here?

MW07 summed up her feelings about how gender impacted the process:

I mean it remains something that makes me sad to this day, that women and babies are not a higher priority in how we spend our money as a government. And I hate that the only thing that gets passed is about abortion. So that said, yes, I don't think I even have to say anything else. I think it was, and it remains, a shame that it's so hard. So then we are all women practicing this profession, and sorry guys, we all love you, but we are invisible still, and certainly the nurse-midwifery profession from a policy perspective. And you know not much has changed there, we've gotten more sophisticated, we've become more

articulate, and I think we found a place where we can express our passion. But the decisions are still made by the guys and the war machine.

Peer Review Discussion

This chapter began with a historical narrative that utilized data from organizational records, congressional bill summaries and federal publications, and 14 interviews of individuals who had been involved with the midwife case over its 19 year history. The narrative told the story of midwife Medicare reimbursement efforts, beginning with ACNM's debut with federal payment legislation in 1977 and all the years leading up to the opening of the midwife case in 1991, and then ending with passage of the Medicare equity bill as part of the Affordable Care Act in 2010.

In order to assure reliability this narrative was shared with three separate auditors who were selected because of their active involvement with ACNM during the years of the midwife case. All three sent comments back to me indicating that they found the narratives to be trustworthy. MWA01 shared this evaluation of the narrative:

This is a comprehensive timeline that taps both the legislative trail and the memories of key participants in this struggle. The professional beliefs that structured ACNM's decisions during this time are well defined. Midwifery's commitment to equitable reimbursement, even when that delayed the desired outcome, is clearly represented.

MWA02 found one section that she thought was misleading in that it did not make clear the fact that midwives were the only ones getting reimbursed at the outset of

the legislative effort; NPs at the time were attempting to be included under Medicare for the first time. I revised that section to clarify that difference, and MWA02 responded with this evaluation:

The narrative is now accurate to the best of my recollection. I also found the structure to be scholarly and technically correct.

Finally, MWA03 shared her recollections as they coincided with the historical narrative. The majority of her reflections reinforced things that were already in the narrative. However, MWA03 included one memory regarding the compromise to move forward without the CMs that had not been shared by any other participant. This had been an issue that had caused significant consternation for one of the midwife case participants. Because the auditor's explanation offers a unique insight into the issue, I am including it here for posterity and future discussion:

As for taking the CMs out of the legislation, my recollection of that was that it was a very difficult decision. The legislators did not want to allow another health care provider designation in Medicare. We tried hard to educate them that the CNM/CM was essentially the same thing, but they were not buying that it was the same credential and were unwilling to add another credential into Medicare reimbursement. It seemed like an ultimatum. If the CMs didn't come out, the 100% did not stay in. It was almost impossible to decide to give up the 100% that we had been working toward for 20 years, when keeping the CM designation in would only affect 50 members. So we decided to take the 100%

and keep working toward the acceptance of the CM designation as a Medicare provider in the future.

The second section of the chapter was an analysis of categories and themes identified in the 14 interviews. There were 226 codes identified that were tied to 579 quotations in the interviews. The analysis revealed 6 categories of themes describing the codes: Policy Agenda, Politics and the Political Process, Relationships, Organizational Capacity, Political Competency, and Gender. Within these 6 categories, 19 themes and 29 subthemes were identified.

In order to assure credibility the thematic analysis was shared with three peer reviewers who were selected because of their qualitative research experience and their familiarity with the midwife case. Two of the three reviewers sent comments back to me. They both verified the correctness of the thematic analysis. MWPR01 had a few minor suggestions which were incorporated into the final draft of the midwife case thematic analysis. These were her comments after reading the thematic analysis:

My impression is that you have adequately and appropriately interpreted the comments of your informants. Your thematic categories are reflected by the quotes you have chosen to include, and represent a robust picture of the process of creating the Medicare legislation, and the environment at ACNM in which that was occurring. You have captured both the insider and outsider perspectives by interviewing staff, officers, and rank and file midwives; this has

generated multiple experiences of the process, and provides a kind of inter-relater reliability for the themes you have identified.

MWPR02 made several suggestions to enhance clarity and accuracy, and made one recommendation to change the category title from Environmental Issues to Relationships. After a phone consultation with the peer reviewer, many of the changes were incorporated into the final document. This was MWPR02s feedback on the thematic analysis:

Overall, this is a well-conceived, credible, and comprehensive presentation of qualitative data collected through interviews with key informants on the topic of the American College of Nurse-Midwives' engagement in a two-decade political process to achieve legislative approval for equitable Medicare status as primary maternity care providers for Certified Nurse-Midwives. The candidate presents the data according to accepted conventions for thematic analysis, providing an overall framework which: reports standardized methodology for thematic conception and extraction, and grouping of quotes; provides rationale for elicited themes; ensures pre and post-analysis content validation of selected codes by a Committee member, and external expert reviewers, respectively; presents the summary of the analysis in a clear schematic table; describes each theme and sub-theme, and provides at least one exemplar quote supporting the concepts. Almost all of the identified themes and sub-themes explain recognizable, credible, and highly applicable phenomena that relate to the experience of study subjects (ACNM leaders and key

informants), the study topic (legislative action on Medicare reimbursement), and impact of end-users (ACNM membership and legislative personnel).

Summary

This chapter began by presenting a historical overview of ACNM's efforts for reimbursement under federal programs: beginning with the first federal payment legislation in 1977; continuing up until the introduction of the first Medicare equity bill in 1991; and then telling the story of the 19 year Medicare equity effort ending in 2010 with passage of 100% equity for CNMs as part of the Affordable Care Act. The chapter continued with a discussion of the thematic analysis of the interviews. Six categories of themes were presented, and 19 themes and 29 subthemes were discussed. Finally, the chapter ended by examining the peer review feedback from the three auditors who had reviewed the historical narrative and the two peer reviewers who had evaluated the thematic analysis.

Chapter 6 will present the findings from the nurse practitioner case. The chapter will follow the same framework as this chapter, beginning with a historical Narrative, followed by a thematic analysis of the nurse practitioner interviews, and culminating in a discussion of peer review feedback.

CHAPTER 6: FINDINGS OF THE NURSE PRACTITIONER CASE

This chapter contains the findings of the nurse practitioner case which was defined as beginning with the opening of the 102rd Congress on January 3rd, 1991, and ending with the signing into law of the Balanced Budget Act of 1997 on August 5th, 1997.

The chapter follows a similar organization to the midwife case. First the Historical Narrative summarizes data collected in the documents review that has been triangulated with the historical data in the NP interviews. Second the Analysis of Interviews summarizes the themes that were discerned from the collected NP interviews. Finally the Peer Review Discussion summarizes feedback from the peer review process and explains how that feedback was addressed.

Historical Narrative

The Historical Narrative was written using the findings from both the document review and the interviews. As noted previously, document review in the NP case was challenging because of the multiple organizations involved in the NP effort, and the relatively early level of professional development of many of those groups. The NP interviews were also more exigent because of the number of years that had elapsed since the case ended. The first question in the interview asked the participant to recount what they remembered historically about the NP effort to

achieve Medicare reimbursement. Where this section of the interview data could be collaborated either by historical documentation or other interviews, it is included to both enhance and enrich the historical narrative.

The narrative is divided into two sections. The first section describes the NP efforts in regards to federal payment prior to 1991. The second section is the time period encompassing the NP case, from 1991 through 1997. The following timeline summarizes the high points of the nurse practitioner Historical Narrative (Figure 6).

Nurse Practitioner Medicare Reimbursement Timeline

Blue years = Democrat Congress
Purple years = Divided Congress
Red years = Republican Congress

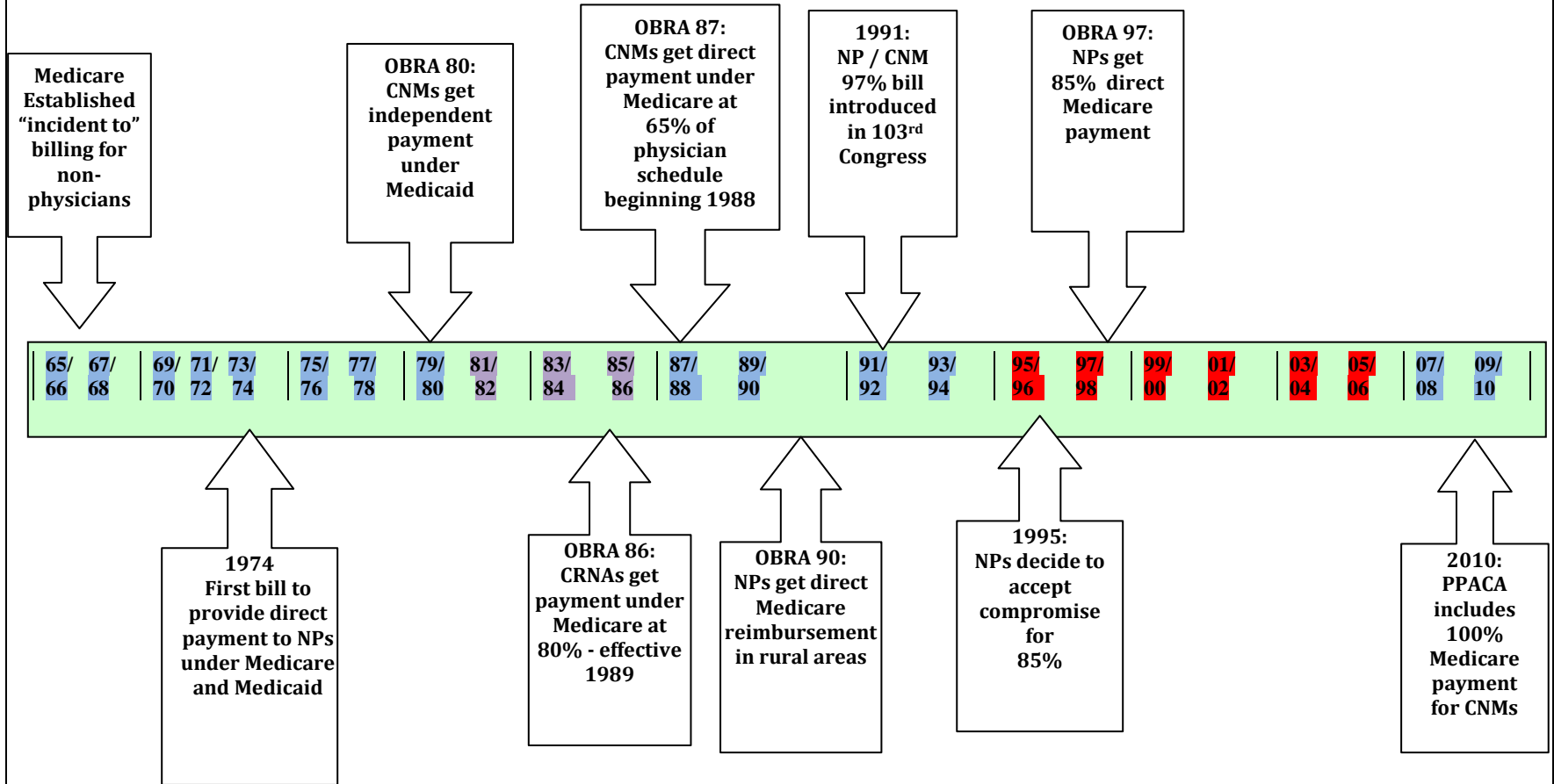


Figure 6: Nurse Practitioner Medicare Reimbursement Timeline

Nurse Practitioners and Payment under Federal Programs

As discussed earlier in the literature review, NPs had little support from ANA and no professional organization to promote their issues during most of the first decade of nurse practitioner practice. The first professional association to represent NPs was the National Association of Pediatric Nurse Practitioners (NAPNAP) founded in 1973. One early NP leader explained this:

NAPNAP was (the first) I believe. And I think the reason it developed that way, of course Loretta Ford had the first nurse practitioner program and that was a pediatric program. And that was really in response for public health need for access to pediatric care...

ANA recognized the need for an organizational home for nurse practitioners during the 1974 Congress of Nursing Practice, and subsequently established the ANA Council of Pediatric Practitioners and the ANA Council of Family Nurse Practitioners. That same year Senator Inouye (D-HI) introduced the first federal legislation addressing payment for NPs in the Democrat led 93rd Congress. *S 3644, A bill to amend the Social Security Act to provide for inclusion of the services of licensed (registered) nurse practitioners under Medicare and Medicaid*, had no Senate companion bill, and saw no action that Congress.

The next time nurse practitioners were mentioned in federal legislation was 1977, during the Democrat led 95th Congress. Congressman Ed Roybal (D-CA)

introduced *HR 5266, A bill to amend titles XVIII and XIX of the Social Security Act to include services of licensed (registered) nurses, physician extenders, and nurse practitioners among the services for which payment may be made under the Medicare and Medicaid programs.* It was likewise during 1977 that the two ANA NP groups merged in to become the Council of Primary Health Care Nurse Practitioners. The California Coalition of Nurse Practitioners was also founded that year.

During both the Democrat led 96th Congress, and the split Democrat House/Republican Senate 97th Congress, Congressman Roybal and Senator Inouye continued to champion Medicare and Medicaid reimbursement for NPs. Roybal sponsored *HR 1140 (96th Congress) and HR 597 (97th Congress), A bill to amend titles XVIII and XIX of the Social Security Act to include services of licensed (registered) nurses, physician extenders, and nurse practitioners among the services for which payment may be made under the Medicare and Medicaid programs.* Inouye sponsored *S 2644 (96th Congress) and S 110 (97th Congress), A bill to amend the Social Security Act to provide for the direct reimbursement of qualified gerontological nurse practitioners under Medicare and Medicaid.* The Senator increased his support of NPs to include the Federal Employee Health Benefits Program (FEHBP) when he introduced *S 2645, A bill to amend title 5, United States Code, to provide for access to qualified professional gerontological nurse practitioners without prior referral in the Federal employee health benefits program* in the 96th Congress. During the 97th Congress Senator Inouye expanded the FEHBP bill to include all advanced practice registered nurses (APRNs) with *S 103, A bill to amend title 5 of the United States Code*

to provide payments under Government health plans for services of nurses not performed in connection with a physician.

By the time the split Democrat House/Republican Senate of the 98th Congress began in 1983 there were four new NP organizations: the National Organization of Nurse Practitioner Faculties (NONPF), the National Association of Nurse Practitioners in Reproductive Health (NANPRH), and the Nurse Practitioner Associates for Continuing Education (NPACE), and the New York State Coalition of Nurse Practitioners; and one organization that formed later that year: the National Conference of Gerontologic Nurse Practitioners (NCGNP). Senator Inouye introduced three NP payment bills during that Congress: *S 172 to provide direct reimbursement to APRNs under the FEHBP program, S 174, to provide that pediatric nurse practitioner services shall be covered under part B of Medicare and shall be a required service under Medicaid, and S 176, to provide that gerontological nurse practitioner services shall be covered under part B of Medicare and shall be a required service under Medicaid.* Additionally Senator Inouye along with Senator Hatfield (R-OR) sent a letter to Congressional Office of Technology Assessment (OTA) requesting studies on the status of NP reimbursement.

The 99th Congress began in 1985, once again with a Democrat led House and a Republican Senate. Senator Inouye introduced four bills that year. Three of them addressed Medicare and Medicaid reimbursement: *S 74, to provide that the services of a pediatric nurse practitioner or pediatric clinical nurse specialist shall be covered under part B of Medicare and shall be a required service under Medicaid, S 76, to*

provide coverage for psychiatric clinical nurse specialist or psychiatric nurse practitioner services under Medicaid and part B (Supplementary Medical Insurance) of Medicare and S 77, to provide that the services of a gerontological nurse practitioner or gerontological clinical nurse specialist shall be covered under part B of Medicare and shall be a required service under Medicaid. The fourth bill, S 136, was to provide payments under Government health plans for services of nurses not performed in connection with a physician. Nurse practitioners also gained a new champion that year. Congresswoman Mary Rose Oaker (D-OH) introduced *HR 3384, the Federal Employees Benefits Improvement Act of 1985*, to provide direct FEHBP reimbursement to NPs, CNMs and clinical social workers. The Oaker bill was the first direct reimbursement bill for APRNs to pass both House and Senate, but it was subsequently vetoed by President Reagan (R-CA).

While Congress considered NP reimbursement under FEHBP, nurse practitioners were busy determining their professional representation. A three day think tank was held in Chicago in 1985 to discuss how best to organize and represent the multiple groups of nurse practitioners. Three of the NP leaders who were interviewed spoke at length about this Chicago Forum and the changes that followed. NP04 stated:

...in May the year before the Chicago thing, NPACE had a meeting where all the nurse practitioners got together and the big complaint was that we weren't getting enough representation on the hill... So we were talking about forming

our own organization, and nobody at ANA was thrilled with that. And so I was on a committee to look at by-laws...

NP02 recalls that the Chicago Forum was a very representative and well run meeting:

It was like a four day thing. And it was very interesting how it was run because first it was just the president and the staff of the various organizations. So it was a total of 25 people. The next day, the next layer of people came like the regional vice presidents and the third day regular members could come. The third day there was like 300 people...

NP04 described what happened when she got to the meeting:

And we came to the Chicago meeting and had a proposal for creating an umbrella organization that would be a membership organization. Well, the other organizations didn't want to have anything to do with that.

NP06 discussed the schism that resulted from this difference in opinion:

But apparently, and I just know this from hearsay, the next day an announcement was made that they were forming the American Academy of Nurse Practitioners... from what I understand is that the group was kind of stunned. They had just spent all this time trying to figure out how they were going to organize... And unfortunately, in my opinion, this created some... distrust that kind of went through for years. And I think that was part of what fragmented the NP groups. And then the idea was well, OK, if we're going to

have these separate groups then maybe we should have something like the National Alliance, which included state groups and the national groups.

NP02 also talked about the breakdown in communication:

So now it's those other groups of practitioners: the pediatrics, womens' health, NAACOG and all these groups want to collaborate, but the AANP doesn't want to collaborate. So they came to the meetings and we all created this thing called NANP, the National Alliance of Nurse Practitioners. So the AANP has always been separate since 1985.

During the second session of the 99th Congress the Physician Payment Review Commission began to explore the impact of non-MD provider reimbursement on Medicare costs and access. The Office of Technology Assessment issued a report outlining the quality and cost effectiveness of NPs, PAs and CNMs. Congresswoman Oakar reintroduced her FEHBP reimbursement bill again as *HR 4825*, and the *Omnibus Budget Reconciliation Act of 1986* included a provision that gave direct Medicare reimbursement to nurse anesthetists at 80% if the physician fee schedule.

The 100th Congress began in 1987 with Democrats once again in control of both the House and Senate. Congresswoman Oakar introduced her FEHBP direct reimbursement bill, *HR 382*, the *Federal Employees Health Care Freedom-of-Choice Act of 1987*. Senator Inouye introduced his three Medicare/Medicaid reimbursement bills: *S 94*, *to provide that pediatric nurse practitioner or pediatric clinical nurse specialist services are covered under part B of Medicare and are a*

mandatory benefit under Medicaid; S 96, to provide that psychiatric nurse practitioner or psychiatric clinical nurse specialist services are covered under part B of Medicare and are a mandatory benefit under Medicaid; and S 126, to provide that gerontological nurse practitioner or gerontological clinical nurse specialist services are covered under part B of Medicare and are mandatory benefit under Medicaid. He also introduced *S 167* to provide direct reimbursement under FEHBP for NPs, CNSs and CNMs. Congress also passed a reconciliation bill (*PL 100-203*) which contained provisions to provide direct Medicare reimbursement to CNMs and to allow HHS to establish four demonstration projects for community nursing organizations. This would be the first time that Medicare paid services would not fall under direct supervision of a physician.

In the second session of the 100th Congress Representative Roybal once again offered APRN payment legislation. *HR 5475, the Nursing Shortage and Nurse Reimbursement Incentive Act of 1988*, would provide direct reimbursement under Medicare for nursing services; and *HR 5492, the National Rural Health Care Act*, would provide direct reimbursement under Medicare for NPs and CNSs. The House held a hearing on the Roybal bills, but they were never marked up and passed out of Committee.

The Democrat led 101st Congress began in 1989. Congresswoman Oakar reintroduced *HR 211, the Federal Employees Health Care Freedom-of-Choice Act*, and Congressman Roybal introduced *HR 1140, the Nursing Shortage and Nurse Reimbursement Incentive Act of 1989*. This time his bill also directed DHHS to study

the obstacles nurses face in receiving direct reimbursement. A third bill was introduced on the House side by Congressman Markey (D-MA), *HR 2673, to amend title XVIII of the Social Security Act to provide coverage of nurse practitioner services under the Medicare program*. On the Senate side Inouye introduced *S 112* to provide direct reimbursement under FEHBP to nurse-midwives and nurse practitioners; and *S 119, to provide that pediatric nurse practitioner or pediatric clinical nurse specialist services are covered under part B of Medicare and are a mandatory benefit under Medicaid*. Inouye's gerontological NP bill and psychiatric NP bill were combined and expanded to include all NPs and CNSs in *S 115, to provide that nurse practitioner or clinical nurse specialist services are covered under part B of Medicare and are a mandatory benefit under Medicaid*. That same year CHAMPUS released a report finding that the fiscal impact of direct reimbursement for NPs was a negligible cost to the federal government. The *1989 Omnibus Budget Reconciliation Act* mandated that PPRC study the implications for the fee schedule of direct Medicare payment to non-MD providers.

In 1990 there were two critical changes in NP reimbursement efforts. Congressman Edward Roybal was Chair of the Treasury, Postal Service and General Government Appropriations Subcommittee, and he included language from the Oakar bill in his Chairman's Mark. That Treasury Appropriations bill passed and was signed into law by President George Bush (R-TX) giving NPs, CNMs and CNSs direct FEHBP reimbursement. Additionally *OBRA 1990* granted direct Medicare reimbursement to NPs and CNSs who practiced in rural areas. As nurse

practitioners passed their 25th professional anniversary they had finally gained initial recognition in federal statutes.

Nurse Practitioners and Medicare Reimbursement

In 1991 the PPRC released its report on non-physician payment. They recommended eliminating the “incident to” payment, and replacing it with a RBRVS differential based on work (educational expenses), practice expenses and malpractice costs. The commission arbitrarily assigned a large educational differential that CNMs and NPs disagreed with. In response ANA and the APRN communities formed a coalition to seek higher federal payment, and hosted a Congressional briefing to discuss the PPRC recommendations. NP02 talked about that effort:

So during those years the nurse specialty groups were getting more active legislatively. And we created a thing called the Nurses Coalition for Legislative Action and we would have monthly meetings... there was a thing created out of the nurses' coalition for legislative action, a small sub group, called the 97% coalition and that was for the specialty organizations that had advanced practice nurses... So this 97% coalition, we were a little group and we were committed and we were going to get this legislation through with 97% reimbursement for nurse practitioners.

NP06 talked about where they came up with the 97% recommendation:

What I remember is... was somebody, and I don't remember who it was, did a relative value scale. You know to figure out the cost of education, malpractice insurance, etc. to figure out what the formula should be. And whoever did that came up with basically a 3% difference between a physician and a nurse practitioner when it came down to that formula.

Senator Inouye introduced his combined NP reimbursement bill when the Democrat led 102nd Congress began in January of 1991. *S 161 would provide that nurse practitioner or clinical nurse specialist services are covered under part B of Medicare and are a mandatory benefit under Medicaid.* However by mid-year NPs and CNSs were in a coalition with CNMs, and the group was actively seeking a designated 97% reimbursement rate under Medicare. NP05 talked about how the liaison with a Republican Senator began:

Grassley was the first one. It was funny because (she) and I went to interview him and give him an award and Ted Tottman was there. And we explained this whole situation and Senator Grassley turned to Ted and he said "I want you to help these women." So Ted sat with us.

In April of that year Senators Grassley (R-IA) and Moynihan (D-NY) introduced *S 2103, the Primary Care Health Practitioner Incentive Act of 1991.* The bill authorized direct reimbursement under Medicare to NPs, CNMs and CNSs at 97% of the physician fee schedule for services performed without regard to setting or practice location. The bill also included a bonus for APRNs who went to work in health professional shortage areas. In the fall of 1991 Senator Daschle introduced *S*

1842 to provide Medicaid coverage of all NPs and CNSs. Meanwhile the 97% coalition continued looking for a sponsor on the House side. NP04 talked about finding a friendly staffer who would prove to be a longtime supporter of nurse practitioners and midwives:

That was Brenda... Pillars, Brenda was really helpful on that side. And she was a true friend to both the nurse-midwives and us and the PAs. And we still miss her terribly but she was the one that got things moving on that side because she was the one who was always there.

Brenda worked for Congressman Ed Towns (D-NY), and in May of 1992 he introduced *HR 4963, the Primary Health Care Practitioner Incentive Act of 1992*, which was the companion to the Grassley bill. The other House champion of NP Medicare and Medicaid legislation had been Ed Roybal, but he was retiring at the end of the 102nd Congress, so his Congressional Hispanic Caucus colleague, Bill Richardson (D-NM) introduced the House companion to the Daschle bill, *HR 4311*, to mandate coverage of NPs and CNSs under Medicaid. In an effort to educate APRNs about the importance of reimbursement politics the coalition of APRN groups held a meeting in DC about nursing reimbursement. But still the numbers of NPs actively involved in advocating for legislation remained relatively small. NP05 lamented about this:

And at the time I didn't feel that many people were doing the work that Jan and I were doing. I just always felt that. We used to go every Friday and sit with

them and it could be an hour or an hour and a half. I didn't see a lot of other people. I'm sure ANA was involved...

In September of 1992 the Senate introduced an omnibus legislation, the *Medicare and Medicaid Amendments of 1992*, which contained a provision for direct reimbursement of NPs, CNSs and PAs at 85% of the physician fee schedule. The bill was on ANA's radar screen, but it was not clear whether the 97% coalition supported this effort. The Amendments passed the Senate but did not pass the House, so the 102nd Congress ended without resolution of the Medicare effort.

The year 1993 brought a Democrat back to the White House with a Democrat Congress. ANA had been active supporters of the Clinton campaign, and the new President Clinton (D-AK) arrived with an aggressive agenda of health reform. ANA national and state leaders were invited to a two hour meeting with First Lady Hillary Clinton to discuss nursing issues in health reform, among which were Medicaid and Medicare direct payment of APRNs. Senator Daschle and Congressman Richardson introduced their direct Medicaid reimbursement bill for NPs and CNSs: *S 466* in the Senate and *HR 1683* in the House. Senators Grassley and Congressman Towns introduced the *Primary Care Health Practitioner Incentive Act of 1993: S 833* in the Senate and *HR 2386* in the House.

It was an active health agenda year in Washington. The Health Care Financing Agency (HCFA) clarified that "incident to" billing required that an MD must be on site and must provide both the initial and intermittent visits to a patient. This made independent practice virtually impossible, and it created difficulties for

nurse practitioners to justify their worth to physician practices or to generate any income. NP03 shared her difficulties that were similarly impacting NPs across the country:

So then I was in urology practice for a year but that reimbursement again was problematic because the physician could bill for the urological procedure and it would get paid for the whole thing and pre and post op was all covered so it was very difficult for me to generate income in the office independent of that because he got all the money upfront for everything. So if I was doing everything upfront or doing post op care that had related to that particular surgical intervention he wasn't getting any more money so after a year there he figured I wasn't making any money for him and why should he pay me so that was the end of that one.

Also that year the DHHS Office of the Inspector General published a report that addressed these difficulties and identified direct reimbursement as one of the major barriers to expanded utilization of CNMs and NPs. This was critical because one of the drivers for health reform was a critical shortage of primary care providers in the country. NP07 looks back:

I don't know that I was so aware of it at the time but in retrospect that was the Clinton healthcare years. And one of the things that NPs were acutely aware of is that there are also an Institute of Medicine report that had been released in 1986 on the future of primary care. And there was initially a lot of recognition for primary care in the Clinton health bill.

As the Clinton Health Reform effort moved forward there were discussions about how to assure competency of nurse practitioners. ANA took the position that defined APRNs as having a master's degree. This was a problem for nurse-midwives and some nurse practitioners who were still being educated in certificate programs. NP06 described how these decisions were viewed by women's health nurse practitioners:

And then we had a long discussion about definitions. And the... legislation said something like "should be registered in the state and nationally certified such as with a pediatric board or ANA, or ANCCs". It was never intended to mean, but not someone certified by NCC... And that became a problem because I had members saying how come we're not named in the legislation... And I think it was also the time when the women's health nurse practitioners, as you know are similar with the nurse-midwives, were the last holdouts on certificate based education. So the language was structured in a way that master's degree or nationally certified or something like that.

Despite nursing's strong support for health reform, there was significant obstruction to the Clinton effort from many key players in the health arena. Physicians were particularly vocal in their opposition to any expansion of advanced nurse practice. NP06 remembered a large scale media campaign against NPs, in which ducks with stethoscopes around their necks were used to portray NPs as quacks:

Did you ever see one of the images from the duck campaign? It was the California medical, the CMA and the Texas group, had this campaign with a duck with a stethoscope around its neck. And then it had a black box warning, like the warning on a cigarette pack, saying, "non-physician providers are looking to get reimbursement from Medicare". And so it was this big poster campaign.

In the end Republican opposition killed the Clinton Health Reform effort, and no legislation was passed. It was a bitter blow for APRNs who had seen this movement as the potential to expand practice through direct reimbursement.

The midterm elections gave Republicans control of both the House and Senate, and the entire political landscape changed with the opening of the 104th Congress in 1995. The American College of Nurse-Midwives, concerned about discussions to tie the master's degree to Medicare reimbursement, and pressure to accept 85% as the reimbursement level, elected to step away from the NP Medicare reimbursement and pursue solo legislation. The rest of the APRN community was also very divided about 97% versus the 85% discussion, and had not come to any consensus when the Senator Grassley decided to pursue 85% in his legislation. NP02 shared her memories of how this unfolded:

We agreed we were going to stick together and 97% was it and from now on all the meetings on the hill were going to say 97%, 97%, 97%. One of the representatives from the American Academy of Nurse Practitioners went to the hill and spoke to Ted Tottman... (who) said nurses will never get 97%. And the

representative asked what we could get and 85% was all we could get. So this... one person, agreed okay. Ted Tottman said okay, the nurse practitioners agreed. We didn't, we had this coalition for a strong 97%. But one person went up and talked to Ted Tottman and... it got put in the legislation and that was that.

Senator Grassley and Congressman Towns introduced the *Primary Care Health Practitioner Incentive Act of 1995 (S 864 and HR 1750)* with 85% reimbursement for NPs and CNSs. Senator Daschle and Congressman Richardson introduced their bill to provide mandatory Medicaid coverage of NPs and CNSs. Grassley's office decided to make the Medicare reimbursement bill a priority. NP04 remembers:

And finally, it was a new congressional session and the republicans had taken over the senate. And we had been working with Senator Grassley's office. And Tim Tottman was the person that was very helpful to us. And when they started moving in on some things related to Medicare his comment to us was "let's get this fixed."

Nurse practitioners understood that it was important to get the legislation scored by the CBO. NP08 spoke about the process of getting the CBO to take up the bill and evaluate it:

I do know that there was an office of budget, the Congressional Budget Office, and they did a report that seemed to be somewhat pivotal. I don't know who got them to do the report, I guess maybe Grassley, whatever. But, they got the

report and found that it was either budget neutral or budget supportive to have that, and that I think that was helpful with the passage.

NP05 believed that it was the 85% decision that eventually helped the bill to be scored as budget neutral:

It's very hard to get some kind of a CBO estimate that wouldn't destroy us. We had something back in 97. In fact we actually went and met with CBO, we might've done that a couple of times. We found out that one of the members of that health staff had a wife that was a nurse practitioner. Somehow we could make a linkage. So we always claimed this would save money because we charged less, and then it became low enough that it wasn't a liability.

The 1995 Omnibus Budget Reconciliation Act included a provision for direct reimbursement of NPs under Medicare. The bill passed both House and Senate, but was ultimately vetoed by President Clinton for reasons other than the NP provision.

NP04 spoke about the frustration they felt:

Well it took a long time to get things passed. We had language in several iterations that ended up in omnibus bills. Then the bills themselves were vetoed by the president and it wasn't because of our issues it was because of other issues.

ANA had actively endorsed President Clinton for reelection in 1996. After the veto of OBRA 95 containing the NP Medicare provision, the White House included a provision for direct Medicare reimbursement for NPs and CNSs when they released the FY97 President's budget in February of 1996. The APRN

community was reenergized, and identified the Medicare reimbursement effort as their number one priority. One NP stepped forward to lead a grassroots effort. NP09 recalls:

I remember in February of...96... I was in an actual meeting with ACNP... what I recall was the number one priority was to pursue Medicare reimbursement... And so I decided... that I was going to pursue a grassroots effort. And I had done that informally at the state level for NPs... I was determined... So I called several people at the American College and one...who is well connected on the hill. And she said... lets... get together and strategize, because part of the effort will be to get the money to pay a lobbyist at the national level... So... I met with (her) in Washington DC and we met with Arent and Fox... and... what we decided to do was develop a strategy.

Although little was happening legislatively during the second session of the 104th Congress several NP case participants spoke about the aggressive efforts of this dedicated advocate. NP09 described the months leading up to the 1996 election:

And then what I started doing is I started, every day for an entire year, after work, I contacted the state organizations or people in other states that were considered to be the quasi leadership... So I did a lot of talking by phone to NPs across the country... At the same time I met with the ANA lobbyist... And certainly they were a force to be reckoned with at the time... And we just decided this really requires a concerted effort... So at the same time I had to raise money and that was a prickly issue to pay lobbyists because the ACNP

didn't have it at the time, and I had to establish credibility like I was going to do this. So I kept in contact every day with everyone to make sure I wasn't going to leave. I made it a point to follow up on every single conversation, with everyone involved in this effort.

President Clinton won reelection and the 105th Congress opened with a Republican majority in both the House and Senate. The President's FY98 budget was released in February 1997 and once again included a provision for direct Medicare reimbursement for NPs and CNSs. Senators Grassley and Conrad (D-ND) introduced *S 370, the Primary Health Care Practitioner Incentive Act of 1997*, and on the House side the companion bill, *HR 893*, was introduced by Representatives Towns and Nancy Johnson (R-CT). ANA mobilized its 40,000 member N-STAT grassroots effort to promote inclusion of APRN direct Medicare reimbursement in the budget reconciliation bill. NP09 continued her grassroots efforts to engage nurse practitioners across the country. NP08 talked about the success of those efforts:

And she was on the phone... every night, and there was e-mail going on as well... she would find out where we needed the co-sponsors and she'd get the people to go and write the congressmen and visit them and so on. And she'd track it all, you know, we've got this one, we got this one. And I think we were all very surprised that it passed. You know, something has to put something like that over a tipping point and I don't know what did it, I can't remember

anything specific, but to my recollection it was just somebody taking it on as a project and working on it tirelessly.

The House Ways and Means Committee approved their Medicare package with the NP/CNS 85% Medicare payment provision included. This Medicare package was then included in the *Balanced Budget Act of 1997, HR 2105*. The *BBA 97* was signed into law on August 5, 1997, and for the first time NPs and CNSs were afforded direct reimbursement under Medicare at 85% of the physician fee schedule.

Fifteen years have passed since NPs were successful in achieving 85% reimbursement under Medicare. Many nurse practitioners thought that 85% would be a starting point that would give them better visibility, and that they would be able to go back and get a more equitable payment later. Neither of those things has happened as yet in 2012. NP01 talked about her frustration with how things have played out:

So as it turned out that's what we got, we got the 85%. And the recognition that we would get all these nurse practitioners and clinical nurse specialists to sign on and start billing directly under their own names and we would collect the data about our services and outcomes and show the CMS what a great job we were doing. How many people were seeing us, we weren't going to be invisible anymore. And as you know that really hasn't happened.

Midwives, who had been doggedly pursuing Medicare equity in the 13 years since NP's got their 85% reimbursement, were able to achieve 100% Medicare equity in the *Affordable Care Act*. Nurse practitioners have had several bills

introduced over the years, but none of them looking at Medicare reimbursement rates. The Medicaid reimbursement bill is still introduced each Congress, now by Senator Inouye and Congressman Olver. In addition, nurse practitioners have bills to allow reimbursement for providing home health care; to permit dispensation of certain narcotics for maintenance or detox without a separate license; and to sanction supervision of cardiac and pulmonary rehab programs. For the time being, it seems, 100% Medicare equity is not on the NP horizon. NP10 reflects:

But I think because we are suffering from so many attacks against their ability to practice to the full extent of the licensure, I think there were bigger attacks than that.... This (health reform) was a good vehicle to do it in, but I think they were looking for other things to ensure their place in health care reform. So the 100% wasn't as important as ensuring their place in other arenas.

Thematic Analysis of Interview Peer Review Discussion

The thematic analysis of interviews discusses categories, themes and subthemes that were identified from the 10 nurse practitioner interviews. The chart below summarizes the 6 categories, 19 themes and 26 subthemes that will be discussed in this section.

Table 4: Nurse Practitioner Themes

Categories	Themes	Subthemes
Policy Agenda (problems and solutions) 30 Codes 65 Quotations	1. Direct Medicare reimbursement for NPs 2. Components of the Medicare bill 3. Enactment of bill and beyond	a. Early efforts at direct reimbursement b. Why direct payment was important a. 85% reimbursement b. Other reimbursement percentages c. Other components of the bill
Politics and the Political Process 36 Codes 60 Quotations	4. The political process 5. What it takes to pass a Bill 6. Politics 7. Political support and opposition 8. Emotions experienced during the process	a. Engaging in the legislative process b. Congressional impact on the process a. Importance of cost analysis and scoring b. Importance of timing and opportunity a. Party Politics b. Political Climate a. Political Porters b. Political Adversaries
NP Relationships 20 Codes 44 Quotations	9. Relationships with nursing 10. Relationships among NP organizations 11. Relationships with physicians	

Categories	Themes	Subthemes
NP Organizational Capacity 41 Codes 97 Quotations	12. Organizational resources 13. Organizational leadership and management 14. Individual and collective nurses and nurse practitioners	<i>a. Size and appearances</i> <i>b. Money and resources</i> <i>a. Professional lobbyist and PAC</i> <i>b. Contributions of volunteers and leadership</i> <i>c. Competing issues</i> <i>a. NP personality characteristics that impact political advocacy</i> <i>b. How NPs are perceived / branding</i>
NP Political Competency 36 Codes 79 Quotations	15. NP Strengths 16. NP Weaknesses	<i>a. Persistence</i> <i>b. Engaging NPs in grassroots political advocacy</i> <i>c. Evolving political sophistication</i> <i>a. Inconsistent strategy development</i> <i>b. Inadequate coalition building</i> <i>c. Not enough collection or distribution of NP data</i>
Gender Issues 22 Codes 33 Quotations	17. Gender impacts political capabilities 18. Gender impacts political reception 19. Harnessing the power of gender	

Policy Agenda

As with the midwife case, the first category identified was Policy Agenda, which here refers to the problems surrounding Medicare reimbursement for NPs and the possible solutions to address those problems. Policy Agenda issues were addressed by all 10 participants, and three major themes were identified: ***direct reimbursement for NPs, components of the Medicare reimbursement bill, and enactment of direct reimbursement and beyond.***

Nine of the 10 NP case participants spoke about ***direct reimbursement for NPs***, and their comments fell into two subthemes: *early efforts at direct reimbursement*, and *why direct reimbursement was important*. NP04 spoke about one of the earliest legislative attempts to address NP Medicare reimbursement:

Well we had an earlier bill... that Inouye put in that was related to long term care and that was when they also made it for rural. So nurse practitioners could direct bill if they were in non-metropolitan statistical areas. So there was that limited piece that went through in the early 80's that was already in place and we started working on trying to expand that. And we were looking at first to just expand it to outpatient but as it turned out we expanded to the entire gamut.

As NPs began to evolve professionally they started to understand *why direct reimbursement was important*. NP05 spoke about how direct reimbursement conveys professional autonomy and professional recognition:

But I think what we were striving so hard for was we knew we did much of the same things the physicians do but we had a different practice model which we felt was pretty important: The teaching, the prevention, the health promotion, more involvement of the family. And we didn't want to give that up. And we wanted the autonomy. We wanted the recognition that we were professional health care providers.

They also realized that direct reimbursement under federal programs helped in efforts to be covered by the private insurers. NP01 explained:

So I think that if I had really thought about it and really looked at it critically, what was really going on with private insurance? And we were trying to get into Aetna and it just wasn't happening. And we had all these doors to get in the provider networks but then we also needed a way to get full reimbursement. So at the end of the day, recognition by the government that we were qualified and confident health care professionals had to be the priorities, because we weren't in anywhere at that time.

All 10 participants spoke about **components of the Medicare reimbursement bill**, and three subthemes were evident: *85% reimbursement*, *other reimbursement percentages*, and *other components of the bill*. Participants spoke about where they thought the *85% reimbursement* came from: some thought it was an arbitrary value; others thought it came from the resource based relative value scale (RBRVS) calculations. But most participants agreed that NPs were not united around the 85% decision. NP01 shared her recollections of how NPs were feeling:

And I remember there being a lot of debate about that 85% thing. People were really pretty rabid about that. They were either yes its great let's get 85%, others were like no it's not the whole thing we should get 100% because it's going to come back and haunt us later. If we don't get it now we're not going to be able to get it later.

There was a lot of discussion about the rationale for *other reimbursement percentages*. Participants believed that 100% was not sellable; despite the fact that it would level the playing field for all practitioners and that the equal pay for equal work argument was very important to them during that time. They surmised that 97% was probably not seen as a benefit to lawmakers, and that the first two times the bill was introduced at that percentage it wasn't taken seriously. It was clear that not all NPs at the time understood how the different percentages were being selected. NP03 shared:

But we were always making comments over that dumb idea, why didn't they go for 100%. And there was some discussion I remember; vaguely the nurse-midwives were only getting 65% or something. And we thought that was crazy and we didn't know what all these number were and how it was coming about.

Several of the NP case interviewees spoke about the *other components of the bill*. There was a discussion of the attempt by some NP groups to eliminate CNSs from the bill in later years, and how ANA fought hard to preserve inclusivity for all APRNs. Participants spoke about the effort to establish a legal definition of APRNs in the legislation by ensuring the soundness of the certification process and defining

NPs as master's prepared. NP10 believed that it was those assurances that helped to pass the bill:

And I think with the assurances, the assurance of credentialing and certification, and that we agreed to a two year Master's degree, putting those requirements in the legislation. They were given a timeline to be Master's prepared, they were grandfathered in before that, and then to be certified.

Finally, four participants spoke about the last theme identified in the Policy Agenda category, **enactment of direct reimbursement and beyond**. All of these interviewees saw the decision to accept 85% ad being a way to get their foot in the door, as NP09 explains:

But our argument I believe at the time was that we had to at least get in the door, and yes some would argue that it cheapened us. And I would say that my opinion ultimately, if we get in the door we can argue a case about our value down the road and work with reimbursement.

The problem, according to NP06, was that there was no strategy to move beyond 85% in the future:

I also think the problem was that we didn't go immediately from, if a compromise was all we were going to get on the 85%, then there wasn't a strategy to get the 97%. It was just like, well we got something, so everyone should be happy and let's see how this works. And then you've got the disjointed efforts. And it's a problem.

Politics and the Political Process

The second category of themes takes into account politics and the political climate as well as the specific legislative processes that must occur in order for policy to be formulated and passed into law. Politics and the Political Process was addressed by all 10 NP case participants, and four major themes were identified in this category: ***the political process, what it takes to pass a bill, politics*** and ***political support and opposition***. In addition there was one minor theme recognized: ***emotions experienced during the process***.

Six of the 10 participants spoke about ***the political process***, and two subthemes were apparent: *engaging in the legislative process* and *congressional impact on the process*. Those who spoke about *engaging in the legislative process* believed that it was important to educate legislators about NPs and to inform the administration about nursing community priorities. NP01 shared that it was important to negotiate language that was supportable by lawmakers:

And I think we had crafted a language that met the middle ground. We had negotiated language already that people could feel comfortable supporting.

The participants who discussed *congressional impact on the process* believed that members will believe in an issue and work towards that a legislative solution for that problem, but when it is over they are ready to move on. NP05 shared how their champion for Medicare payment did not choose to take on the other NP issues:

I think people on the hill, you being one of them, I think they feel they help you and most of them don't want to keep their feet in the fire. I think Ted found

that he helped us a lot, they probably got criticism from medical communities and he wasn't going to do the homecare.

Seven of those interviewed spoke about **what it takes to pass a bill**. There were two subthemes in their interviews: the *importance of cost analysis and scoring*, and the *importance of timing and opportunity*. The *importance of cost analysis and scoring* included concerns over the cost of adding NPs, and confusion over how to count NPs. Participants spoke about trying to get a CBO score that wouldn't destroy the effort, and how important it was to appear cost effective. NP07 shared how that impacted the decision to accept 85%:

And a lot of the argument hinged around how do we make the argument that we're cost effective. Because if we push to charge 100% we cannot go to congress and say look how cost effective we are. We don't have an argument. So that argument won the day.

The second subtheme in **what it takes to pass a bill** was the *importance of timing and opportunity*. NP05 talked about the importance of having everything in place when the opportunity arises:

I don't think, of course we had to get a CBO estimate, but I don't think everything was in place and we didn't have the window that we had in 1997. You have to kind of wait for that... window of opportunity.

The third theme in the Politics and Political Process category was **politics**. Five of those interviewed identified **politics** as a factor in the legislative effort, and their comments fell into two subthemes: *party politics* and the *political climate*. The

first subtheme of *party politics* referred to the partisan nature of politics. They spoke about the importance of having bipartisan support, and of ensuring that the NP issue was seen as bipartisan. Even though nurses tend to assume they will be more successful in a Democrat Congress, NP04 makes the point that this issue was led by a Republican:

And the one thing I point out to people is that it doesn't have to be a Democrat in order for things to go through. We passed that in a Republican Congress.

Political climate was the other subtheme identified. This included the impact of the Clinton health reform effort, the shortage of primary care providers and the projected influence of the baby boomers on Medicare. NP08 shared this about political climate:

The economic and excess factors wax and wane in and definitely have a place in whether these things pass or not... It seems like...there's been very little movement, just very small increments, and why is that?... I do think economic and social factors make a difference.

Seven of the 10 participants spoke about the fourth theme, ***political support and opposition***, which had two subthemes: *political porters* and *political adversaries*. The participants talked about the importance of *political porters*, and how it was critical to make the right connections and choose the right sponsors. NP10 recalls:

I think also our team had been working with Members in the House and Senate on this issue before and had gotten significant support... and I think we had

already developed relationships with the sponsors, and with those key members... we had a lot of people who we had connected with, and we were now engaged in the political game, by endorsing the President... And now with Administration support or White House support the chances were greater.

The flip side of having porters to help carry legislation was the problem of having *political adversaries*. NP07 related finding out that they had an unexpected adversary:

It was also clear that HHS was the one that did a lot of pushback. It wasn't congress, HHS. I remember being told specifically that they did not want to add any more providers because it would just add costs to the budget. And that was coming from HCFA. And their philosophy was that if you opened the door, the door was a little bit opened.

The final theme in this category was ***emotions experienced during the process***. Three of those interviewed spoke about this minor theme. They thought that that the process was long and frustrating, but very exciting when it was over. NP09 shared her feelings about passage of the bill:

So when it passed it was a glorious day but I was exhausted. After a year of doing this every day, it was very exciting...

NP Relationships

In the political arena one critical factor for successful policy advocacy is the relationship with other special interest groups and their input into the political

process. Nine of the 10 NP case participants spoke about the category of Relationships, and three specific themes were identified: ***relationships with nursing, relationships among NP organizations, and relationships with physicians.***

Eight interviewees discussed the NP ***relationships with nursing.*** There were varied opinions about how nursing impacted the NP effort for direct Medicare reimbursement. The participants spoke about early ANA opposition to NP legislative efforts, and felt that ANA had not been responsive to NP needs during the early years of the profession. NP02 talked about an encounter with ANA during the early years of the NP movement:

The ANA, they didn't like us messing with the legislation. They wanted to do it all themselves. I had been hired by NAACOG in 82' and I was so happy... So she... was the head of the Washington office. And she called me and invited me to lunch at the Capitol Hill Club. And we're sitting there having lunch and she says to me, this innocent little happy NAACOG employee, get the hell out of legislation. I left there and went to the NAACOG office and closed my door and didn't know what to do... To have been told this by the ANA staffer, get the hell out of legislation... So that was way back a long time ago. Now they tolerate the specialty groups.

There was some conflict expressed over who speaks for NPs, but there was also an acceptance that the association with ANA gave legitimacy to the effort. NP10 shared these views about ANA's role in the Medicare reimbursement effort:

People didn't want ANA to be the lead on anything, especially when it came to advanced practice. And I think to this day that holds true. However they understand what we can leverage at times to help... But I always viewed that we were the lead group on this issue. That maybe we had some conversations, but we were the lead.

Eight participants spoke about **relationships among NP organizations**.

They shared that there was competition between the different NP groups, and poor communication led to an element of distrust between some groups. NPs didn't know which organization to join, and the different groups had difficulty speaking in one voice. NP09 spoke about the confusion this created:

Well speaking in different voices was kind of like having 15 constituents call you about one issue... Because there are multiple organizations... and one organization would say we represent the NPs as you know... So I think when you had so many organizations who stated they represented the nurse practitioners, and that certainly got confusing.

Finally, seven of those interviewed spoke about **relationships with physicians**. They saw physicians as having autonomy in the health care arena, but being threatened by the nurse practitioner movement and actively opposing any effort to expand practice for NPs. NP05 talked about Senator Grassley's courage in helping the nurse practitioners despite physician opposition:

I think it was a great feat, because looking at it after the fact he took a chance, and maybe even regretted it after he did it. Because he probably had the

medical community all over him for doing it. But of course it allowed us to really go forward and to gain some status in the healthcare arena. That's when we started having more problems with physicians. They were nervous and they seemed more determined to squash this out or limit it.

NP Organizational Capacity

NP Organizational Capacity is the terminology selected to describe factors or characteristics that are intrinsic to the nurse practitioner profession and its professional representation. NP Organizational Capacity at the time of the Medicare reimbursement effort was a factor in the legislative efforts of the different NP groups. All 10 respondents spoke about NP Capacity, and three themes were identified within this category: ***organizational resources, organizational leadership and management, and individual and collective nurses and nurse practitioners.***

Seven participants discussed ***organizational resources***, and there were two evident subthemes: *size and appearances* and *money and resources*. Those interviewees that spoke about *size and appearances* discussed how few NPs there were at this time, and noted the fact that they were in multiple organizations. Some felt that they were beginning to reach a critical mass as this policy effort was happening. But others felt that the success of the legislation was due to the power of the nursing numbers coupled with the fact that multiple organizations weighing in on the issue had the impact of making the issue look bigger. NP09 put it this way:

And we said that the growing of our organizations, even though there may be too many organizations, all put together made a huge impact on the process. Remember the grassroots component; they were members of all these organizations. So they (legislators) got the message in several different ways... When they all worked together as a team with one simple message, I think the fact that there were so many organizations that were in agreement that this needed to be passed... I think ... did make a difference.

The participants also spoke about the impact that *money and resources* had on the effort. While everyone agreed that these are critical ingredients in a policy effort, there were different perceptions as to whether or not there was enough of either of these to produce a successful outcome. NP03 saw the movement as being very compromised in resources:

We didn't have any money to speak of and we didn't have any resources other than a few nurses who lived around the area or the organizations who had home offices there. So I would say we were relying on a small cadre of NPs to do the bidding for us with great enthusiasm from time to time from around the country to develop a grassroots movement to do stuff.

However NP10 pointed out that ANA brought a huge amount of *money and resources* to the effort:

And our team at that time was much larger than it is now. Much, much, much larger. It was a huge team. And we were very specified in what we did... We had the money, we had the resources, we had the visibility. We had grassroots.

I think that played a huge role. And we were just coming into becoming a power on Capitol Hill that could... confront the big players. And that we could be as strong as many of the unions.

All of the NP case participants spoke about **organizational leadership and management**, and there were three subthemes identified: the importance of the *professional lobbyist and PAC*, the *contributions of volunteers and leadership*, and *competing issues*. Understanding the importance of having a *professional lobbyist and PAC* was a developmental realization for NPs. While ANA was quite sophisticated by this time in its political activities, many of the smaller NP organizations were just beginning to realize how the Washington game is played. NP03 talked about she tried to convey this message to her NP organization:

We realized we had to donate money to influence legislators in Washington and be organized as a body and we had an office in DC... I was the one that said we had to... be part of this group, we have to be at the table with these people because this is where our legislation is happening. And I was like the lone voice crying in the wilderness, but said I would donate whatever it costs...

Respondents spoke about the *contributions of volunteers and leadership* in the Medicare reimbursement effort. They felt that there was strong NP leadership going on, and the influence of many people made a difference. However several people pointed to one passionate volunteer who led a very aggressive grassroots effort. NP08 talked about this remarkable NP volunteer:

And my recollection is that some point (she)... had heard all that stuff as well, and she just took it on as a project And I believe she basically said, how can we get this passed? And she found out, you know, who we needed to target in terms of getting congressional sponsors, co-sponsors, and then later who we needed to target in terms of votes... And it was simply... a matter of she spent every night at this for about a year... there's clearly lobbyists in the organizations, but I mean there was somebody who was actually getting people who were not involved previously... to go down to their congressional office and sit there... She was doing the work that a really good lobbyist would do for free.

The last subtheme identified was *competing issues*. Half of the participants spoke about the other issues that have impacted NPs over the years in Medicare. They point to those issues as a way to explain why NPs have chosen not to revisit their reimbursement percentage to try and get a more equitable payment rate. NP03 lists a few of the competing issues that still plague NPs today:

What nurse practitioners could get reimbursed for in the nursing homes versus the SNF care... We were also fighting for admitting privileges in the nursing home and we still haven't won that battle. And were fighting to order Hospice care and we still haven't won that battle. And we still haven't won the battle for PT/OT completely either. So the same old battles have been going on for like what, 20 or 30 years.

The final theme under Organizational Capacity was ***individual and collective nurses and nurse practitioners***. Nine of the ten NP case participants spoke about

this theme, and two subthemes were identified: *personality characteristics that impact political advocacy* and *how NPs are perceived / branding*. Participants in the NP case talked about *personality characteristics that impact political advocacy*, including not being able to find time for advocacy in their busy profession, fear of rocking the boat, and the fact that NPs didn't understand the importance of direct billing and some were not seeing many Medicare patients. A significant percentage of the NPs at the time were pediatric and women's health NPs, and MW06 explained how this impacted their interest in the Medicare legislation:

And the other thing... it was a time when women's health nurse practitioners weren't seeing that many older woman. The Medicare patients that they saw were generally somebody who would be someone who had special needs, social security, that type of thing, and the numbers were very small. And when I would ask my membership does Medicare funding really matter to you, of course that's all changed.

NP interviewees also spoke about *how NPs are perceived / branding*. Despite the positive perception of nurses, nurse practitioners were seen as having been invisible in the system and not fully recognized yet. NP01 described the status of the early nurse practitioners:

I think we'd have more of a position now than we did in the 90's. We didn't have the IOM report, nobody knew who we were, we were still seen as a kinky sort of fringe group of nurses and nobody really knew what we were about. And there were still a fair number of us who were not graduate educated; there were still

a lot of us who had baccalaureate and associate degrees or the certificate graduate program. So I think that it was a very different environment than it is now.

NP Political Competency

The term political competency is used here to describe the basic aptitude of the nurse practitioners individually and collectively to impact the political process. All 10 NP case participants talked about NP Political Competency, which was divided into two themes: ***NP strengths*** and ***NP weaknesses***.

Ten participants discussed different ***NP strengths*** that impacted the Medicare reimbursement effort, and three subthemes were delineated: *persistence*, *engaging NPs in grassroots political advocacy* and *evolving political sophistication*. The respondents who cited the *persistence* of the NP organizations as a strength described constant attention to the legislation and constant evaluation. They felt that NPs had been able to learn from their mistakes and move forward. NP05 spoke about what that meant for her:

I think what (we) had was a lot of passion, we had a lot of persistence and you have to have that when you go to talk to people. You might be lobbying for something and think it's a good idea, but if you don't have that personal passion and make that personal connection, and then do it over and over again, I don't think you do a lot of convincing. It was more than a job for us.

Most of the participants thought that *engaging NPs in grassroots political advocacy* had been a strength of a few volunteer leaders. In order to build support for grassroots efforts it was important to educate and empower NPs to be political advocates. NP09 described her efforts to coach NPs to be effective advocates:

Because she like many other wanted this to pass but they didn't know how to lobby. So I had to coach them about how to lobby, and I gave them material. We reviewed the material... I followed up on each phone call again... I was going to work with them and move them forward in collaboration with me and others. And it was so exciting because in my opinion it seemed to empower the nurse practitioners, that they really could make an impact if they worked together as a team regardless of organizational affiliation.

Several of the interviewees cited *evolving political sophistication* as a strength. They believed that NPs had started as amateurs at political advocacy, but that they had become more politically active and grown more politically savvy over the years of the Medicare effort. They recognized the importance of a presence in DC, and one interviewee noted that during the years of this legislation they had more professional Hill presence than midwives. NP03 spoke about the evolution in her organization:

And during the time I was on the board we really... got off the porch and started playing with the big dogs as we said back in the day, because we started becoming more nationally recognized. And we had more members who were

lobbying and we got more involved in legislation and tried to figure out what was going on.

Nine NP participants spoke about **NP weaknesses** that influenced the policy efforts, and three subthemes were recognized: *inadequate coalition building*, *inconsistent strategy development* and *not enough collection or distribution of NP data*. The single biggest weakness identified was *inadequate coalition building*. The participants recognized the missed opportunities to build organizational unity and the failure to work in coalition. There were times when the individual organizations were seen as not being able to put the good of the collective effort ahead of personal interests. NP10 shared why she thought this had been such a problem:

But also I think it was a time when each of those groups were trying to create a name for themselves. So cooperating or working collaboratively, not showing that you are the lead, doesn't bode well for creating a name for yourself.

The second **NP weaknesses** subtheme was *inconsistent strategy development*. The respondents were actually divided on whether or not NPs had been reactive or proactive about the Medicare effort, and many felt like there had been concerted attempts to develop a strategy. But the weakness seen by a few participants was that there was no strategy to move forward after 85%. NP06 shared this critique:

I think there was a lot of reactivity. I think the final decision was reactivity. We might've held out, I can't remember why it became important to accept the offer. And you know again, maybe that was the best inside information that was had. I think where there was no proactive effort was where I just described

it. There was nothing from the 85% to say our next step is to get 97, how are we going to do that? And it still isn't.

The final **NP weaknesses** subtheme identified was *not enough collection or distribution of NP data*. NP05 discussed the failure to prioritize data collection in the individual or collective NP organizations:

What I have felt has been absent all along even to right now is the data component. I think we should have plummeted the hill with data, more articles should have been written. We should have had more people that receive services from nurse-midwives and NPs to talk to their legislators about it. I know when we make our visits I don't think there is one staffer that doesn't ask is there a study or is there a CBO estimate or is there data. And we can talk though some of that but if I headed one of these organizations I would have a whole department that was just generating.

NP07 shared that even the data NPs did have was not distributed effectively, and they did not have the wherewithal or resources to use public relations media to benefit the profession:

They could have had much more effective messaging. There was a lot of that NPs could not do because of lack of funds. There were conversations about trying to do ads on television and nobody had any money to do it. It just wasn't going to happen. So while the groups tried to create a real messaging that didn't happen. You know that could've been much more effective.

Gender Issues

The final category of themes involved Gender Issues. Gender Issues is a category that every participant spoke about specifically because there was an interview question about the impact of gender. All 10 participants spoke about one or more of the three themes identified: ***gender impacts political capabilities***, ***gender impacts political reception*** and ***harnessing the power of gender***.

Nine of the participants considered how ***gender impacts political capabilities***. They described women's difficulty in finding time for political advocacy, and thought that although women may not be inherently drawn to advocacy they can definitely be taught to be effective in the policy arena. A big problem they saw, however, was women's inability to band together for a common cause. NP06 explained how that hurts nursing:

I think gender plays a huge role. I think gender plays a huge role in the entire profession of nursing. Not just nurse practitioners, not just nurse-midwives, you know the inside joke is that nurses know how to circle their wagons, they just don't know you're not supposed to shoot in. My experience with that is to this day.

A few participants thought that men had more characteristics that made them want to be engaged in political advocacy, but others believed that each gender had similar challenges in getting professionals to be involved in policy. NP04 compared the two and found that women might actually have an edge when it comes to advocacy:

I don't think there is any difference between men and women in that. I think in either gender you have people who become proactive and you have people who aren't interested in being proactive and you have just as many men who aren't interested in politics as in women... I think women, you know, one of the things we see on the Hill when we're dealing with these kids, when they're feeling miserable or they're having a tough day and you're sympathetic and give them the mothering and before long they're doing all types of things for you. We have skills that we can use that the men will never use.

Seven of the NP case interviewees spoke about how **gender impacts political reception**. They saw Congress as a male model thinking body, and felt that many policymakers don't take women seriously. They also felt that it was sometimes difficult to separate gender from the status of nursing, which has never commanded as much respect as medicine. But in general they felt that the problems with political reception are similar to problems women have in other high powered arenas. NP07 shared her thoughts on this:

Men are still in most of the CEO positions and still seem to be listened to. Women will say something in a meeting and people will either nod or say nothing. But if a man says the same thing it's the greatest idea since sliced bread... And I think that's true when you speak to male staffers but there's now a lot of female staffers on the hill now... I think I have often thought that the payment issue was...let's be nice to the girls. Let's do something nice for the girls. And I don't have any evidence to say that but it's sort of the dynamic. I

don't know that women are even yet taken as seriously in business and politics than men.

Seven NP participants spoke about ***harnessing the power of gender***. They believed that gender had helped the PAs get ahead quicker than NPs, and that with more men entering the nursing profession things have started to change. NP03 spoke about the influence men are having on the NP profession:

But I think nowadays we have more men involved and a lot of men who become nurse practitioners become very active in their association and become more entrepreneur and business people. So it seems like a lot of them get their PhDs and write big papers and do wonderful work at the universities. And I think that the men are helping us move along a little bit in a more collegial way. And it's nice to have their point of view because they do things differently than women but we're all part of the same family as nurse practitioners.

A few participants thought that some legislators bond with men and some with women, so it is important to have both genders involved in an advocacy effort. But in the end, most agreed that gender was, and still is, power in the political arena. NP10 summed it up with these words:

I think gender plays a huge role, huge, huge role. And I think still today plays a huge role in how we advance our issues and the role we play in the political arena. And I think our leadership at that time... had the vision that we had to become stronger and had to learn how to play like they played... But I still

think we suffer from the gender issue. And I think gender is why we got 85% and not 100%.

Peer Review Discussion

This chapter began with a historical narrative that utilized data from organizational records, congressional bill summaries and federal publications, and 10 interviews of individuals who had been involved with the nurse practitioner case over its 6 year history. The narrative told the story of NP Medicare reimbursement efforts, beginning with the first federal payment legislation introduced for NPs in 1974 and all the years leading up to the opening of the NP case in 1991, and then ending with passage of the direct Medicare reimbursement bill as part of *OBRA 97*.

In order to assure reliability this narrative was shared with two auditors who were selected because of their active involvement with different NP organizations during the years of the NP case. Only one of the two auditors got back to me, despite a follow-up email to remind the second volunteer of the deadline. NPA01 responded with several suggested edits and recommendations for better clarification of the narrative. These were incorporated into the revised account. Overall NPA01 stated that she found the narrative to be trustworthy, and shared this review:

This historical description of how nurse practitioners came to be recognized and paid directly by Medicare is as thorough, accurate and detailed that I have seen. It is a long and winding road and this federal viewpoint of all of the streams involved, the messy congressional legislative process, the ever-shifting executive branch and the politics are all interweaving and interacting. What

strikes me is the accurate retelling of the decades-long journey to NP reimbursement, how astute NPs became at managing the politics. The best example of NP political competence is when they leveraged their knowledge of a spouse of a CBO employee who was an NP to help CBO understand the value of NPs. This description pulls together a great story of how it became necessary for NPs to corral their political power to achieve what they could not achieve individually. This narrative will be a great help to graduate students to provide a strong context for where we are today and how advanced practice nursing must unite and be more forceful to vastly reform and improve health care in the United States. It emphasizes Rudyard Kipling's quote, "The strength of the wolf is in the pack."

The second section of the chapter was an analysis of categories and themes identified in the 10 interviews. There were 185 codes identified that were tied to 378 quotations in the interviews. The analysis revealed 6 categories of themes describing the codes: Policy Agenda, Politics and the Political Process, Relationships, Organizational Capacity, Political Competency, and Gender. Within these 6 categories, 19 themes and 26 subthemes were identified.

In order to assure credibility the thematic analysis was shared with two peer reviewers who were selected because of their qualitative research experience and their familiarity with APRN payment policy. Both reviewers sent comments back to me verifying the correctness of the thematic analysis. NPPR01 noted that it would have been helpful to have received the demographic table along with the analysis,

which I found to be a very valid criticism of the review process. She shared the following observations about the thematic analysis:

The analysis of 10 nurse practitioner interviews into 6 categories, 19 themes and 26 subthemes appear in a logical, evolving progression. It was impressive that many of the categories the NP's were very consistent in their thoughts while on a few issues, they had divergent ideas on how issues were discussed. The discussion on the relationships among the NP organizations is not surprising. Each organization feels they are doing the best for their members. The content from the interviews is rich with the experiences of the NP's.

NPPR02 pointed out two places in the thematic analysis that she would have liked to have seen further developed. I reviewed those sections and attempted to incorporate her suggestions. In general NPPR02 found the analysis to be relevant and useful:

In my role as reviewer, I was asked to read and comment on a 20 page thematic analysis. The analysis lays out and discusses categories, themes, and subthemes that emerged from interviews with 10 nurse practitioners. Direct quotes from study participants are included to demonstrate that the themes are grounded in the data. From my perspective, the findings appear to be relevant and useful in describing the phenomena. The inductive coding served the intended purpose – to uncover meaning - and the qualitative findings effectively capture the richness of the phenomena. Based on what I have reviewed, the analysis appears to be thoughtful and well-done. As a reviewer, I found the reading

intriguing and in the end, it helped to significantly enhance my understanding of the phenomenon. The study has direct application and post dissertation dissemination will help to inform current and future activity by nurses as they engage in policy and political activity.

Summary

This chapter began by presenting a historical overview of nurse practitioner efforts for reimbursement under federal programs: beginning with the first federal payment legislation in 1974; continuing up until the introduction of the 97% Medicare reimbursement bill in 1991; and then telling the story of the 6 year Medicare payment effort ending with the passage of 85% reimbursement for NPs as part of OBRA1997. The chapter continued with a discussion of the thematic analysis of the interviews. Six categories of themes were presented, and 19 themes and 26 subthemes were discussed. Finally, the chapter ended by examining the peer review feedback from the one auditor who had reviewed the historical narrative and the two peer reviewers who had evaluated the thematic analysis.

Chapter 7 will present a comparative analysis of the two cases. It will follow a similar profile as Chapters 5 and 6, beginning with a comparison of the two historical narratives, and then comparing and contrasting the two thematic analyses. The chapter will conclude by using the findings from Chapters 5, 6 and 7 to answer the study questions, looking specifically at process length of time, process outcome, the impact of gender and the impact of economics and special interest politics.

CHAPTER 7: COMPARATIVE ANALYSIS OF MIDWIFE AND NURSE PRACTITIONER CASES

This chapter compares the findings of the midwife case with those of the nurse practitioner case. Both the CNM case and the NP case were defined as beginning with the opening of the 102rd Congress on January 3rd, 1991. The NP case ends with the signing into law of the Balanced Budget Act of 1997 on August 5th, 1997. The CNM case ends thirteen years later with the signing into law of the Patient Protection and Affordable Care Act on March 23rd, 2010.

The chapter begins with a comparison of the findings from the two historical narratives. Following that, the two thematic analyses of the interviews are analyzed for similarities and variances. Finally, the findings from these two comparative analyses are used to answer the first research question and its two subquestions:

1. Why did ACNM and the NP organizations fare so differently in their efforts to achieve payment equity?

Specifically:

- a. Why did the process take 6 years for NPs but 19 years for the CNMs?
- b. Why were the NPs successful in achieving only 85% reimbursement while the CNM legislative endeavor resulted in 100% reimbursement?

Finally, patterns identified from the Historical Narratives and the Thematic Analysis of Interviews are compared to the two theoretical frameworks postulated in the first chapter to have relevance in explaining the legislative processes and outcomes in the midwife and NP cases. These analyses are then used to answer the second and third research questions:

2. What role, if any, did gender play in the CNM and NP Medicare legislative endeavors?
3. How were the efforts of CNMs and NPs to achieve equitable Medicare reimbursement impacted by special interest politics?

Historical Comparison

The historical comparison is done utilizing the two historical narratives. In order to better frame the starting point for the two Medicare policy endeavors, this section first addresses the early federal policy efforts of CNMs and NPs to attain federal payment status. Then the CNM and NP cases are compared for historical parallels and distinctions. The following timeline summarizes the high points of the midwife and nurse practitioner historical narratives.

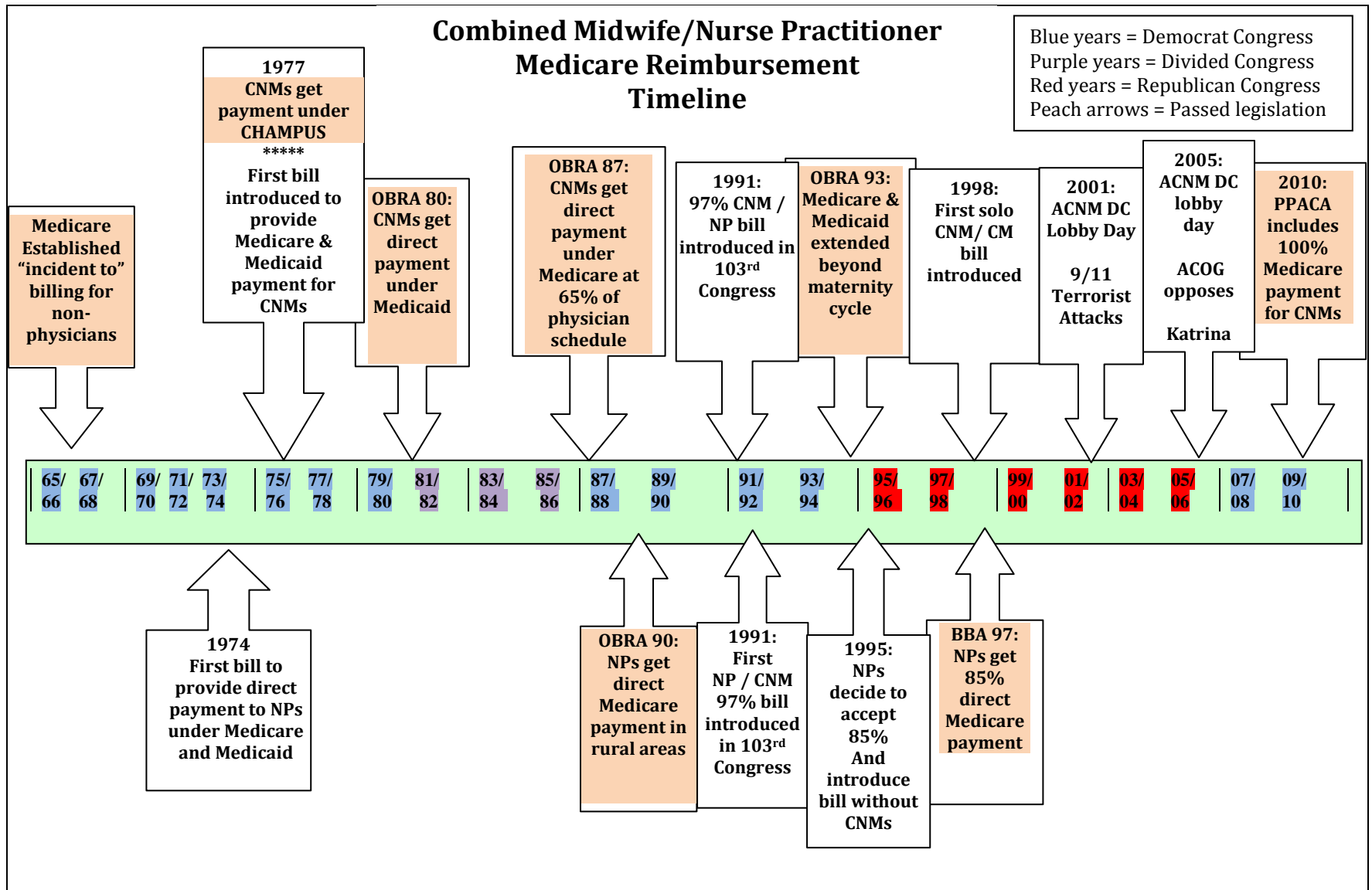


Figure 7: Comparative CNM/NP Medicare Reimbursement Timeline

Early Midwife and Nurse Practitioner Efforts for Federal Payment

When Medicare and Medicaid were established in 1965, nurse-midwifery had been a recognized profession in the US for approximately 40 years. Midwives had been represented by one or more professional organizations since 1929, and ACNM had been the primary national organization since 1955. In contrast, the first nurse practitioner program was just opening, the concept of the nurse practitioner as professional was in its infancy, and there were no professional organizations representing the nurse practitioner. The Medicare statute allowed nurses to be reimbursed as “incident to” a physician at 100% of the physician fee, but the physician needed to be present and to initiate the billing for reimbursement. Nurse-midwives and nurse practitioners, as nurses, were considered eligible for incident to billing, but were not named separately anywhere in the federal statutes.

The first legislation to address federal payment for either midwives or nurse practitioners was introduced in 1974 during the Democrat led 93rd Congress by Senator Daniel Inouye (D-HI). The bill, which would provide direct reimbursement for nurse practitioners under Medicare and Medicaid, had no House companion and saw no action. In contrast, nurse-midwives were not mentioned in federal legislation until 1997, during the Democrat led 95th Congress, when Senator Inouye introduced a bill to provide direct Medicare and Medicaid reimbursement to midwives.

The first House legislation to address federal payment for midwives or nurse practitioners was also introduced in 1997, when Congressman Ed Roybal (D-CA) sponsored a bill to give direct payment to nurse practitioners under Medicare and Medicaid. Midwives were not named in any House legislation until 1979 when Congresswoman Mikulski (D-MD) introduced a bill to grant direct reimbursement to midwives under Medicare and Medicaid.

Although nurse practitioners were first to be named in both Senate and House federal payment legislation, midwives were the first to be named in federal payment statutes. During that same 95th Congress a bill introduced by Senator Inouye to allow CNMs and Psychiatric Nurses to be independently reimbursed under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) was passed and signed into law.

Over the next ten years midwives were much more successful in federal policy efforts than nurse practitioners. First, in response to a Congressional Budget Office report recommending greater use of nurse-midwife teams, language from Mikulski and Inouye bills was included in *OBRA 1980* and CNMs were granted direct reimbursement under Medicaid for obstetrical services. Then in the Democrat controlled 100th Congress Senator Inouye's bill to provide Medicare payment to midwives was included in *OBRA 1987*. When that omnibus legislation passed, it established direct Medicare payments for CNM services, limited to the maternity cycle, at 65% of the physician fee schedule. Midwives now had direct payment

under both Medicare and Medicaid, and nurse practitioners had yet to be named in a federal statute.

The Democrat led 101st Congress that began in 1989 saw two critical changes in NP reimbursement efforts. Congressman Roybal, a longtime supporter of both nurse practitioners and midwives, was now Chair of the Treasury, Postal Service and General Government Appropriations Subcommittee. He included language to give NPs, CNMs and CNSs direct FEHBP reimbursement in his Chairman's Mark, and that Treasury Appropriations bill was signed into law by President Bush (R-TX). Additionally *OBRA 1990* granted direct Medicare reimbursement to NPs and CNSs who practiced in rural areas. As nurse practitioners passed their 25th professional anniversary they had finally gained initial recognition in federal statutes.

The Midwife and Nurse Practitioner Cases

This was the federal payment situation for CNMs and NPs when the Democrat led 102nd Congress began in 1991. Midwives had direct payment under Medicare (at 65%), Medicaid and FEHBP. Nurse practitioners had direct payment under FEHBP and under Medicare only if they practiced in rural areas. Midwives were represented by ACNM, while nurse practitioners were represented by ANA, AANP, the Alliance, and several specialty NP organizations. Midwives were seeking higher Medicare reimbursement because they were concerned that other payers would adopt the Medicare payment percentage. NPs were looking for direct payment under Medicare at the highest possible level. The APRN community

decided to form a coalition to seek Medicare reimbursement at 97% of the physician fee schedule.

Until the introduction of the *Primary Care Health Practitioner Incentive Act of 1991*, all the champions for NP and CNM legislation had been Democrats, and all the advancements in federal payment statutes had taken place during Democrat controlled Congresses. So it was a divergence when the coalition selected a Republican champion in Senator Grassley to lead the effort for 97% Medicare reimbursement. Although Grassley served on the Senate Finance committee that had jurisdiction over Medicare, the Congress was still controlled by Democrats. The following year a House companion bill was introduced by Democrat Congressman Ed Towns, a member of the Energy and Commerce Committee. In September of 1992 the Senate introduced a Medicare and Medicaid omnibus legislation which contained a provision for direct reimbursement of NPs, CNSs and PAs at 85% of the physician fee schedule. The NP amendments, which were not actively supported by the APRN 97% coalition, passed the Senate but did not pass the House, and the 102nd Congress ended without resolution of the Medicare effort.

The 103rd Congress began in 1993 with Democrats still controlling both the House and Senate, and a new Democrat President in the White House. President Bill Clinton (D-AK) began his term with an aggressive agenda of health reform, and nursing leaders were invited to a meeting with the First Lady to discuss nursing priorities for health reform, which included direct Medicaid and Medicare payment of all APRNs. The HHS Office of the Inspector General released a report that

identified direct reimbursement as one of the major barriers to expanded utilization of CNMs and NPs. This was critical because one of the drivers for health reform was a critical shortage of primary care providers in the country, and health policy analysts were looking at APRNs to fill those gaps. The 97% Coalition worked together in the 103rd Congress hoping that health reform efforts would be successful and the Medicare reimbursement provision would be a part of any bill that passed.

While NP organizations were solely focused on Medicare reimbursement, ACNM continued to pursue other avenues to expand federal payment statutes. In 1993, amendments offered by Congressman Bill Richardson (D-NM) and Senators Jay Rockefeller (D-WV) and Patrick Moynihan (D-NY) to extend the payment of nurse-midwives in Medicare and Medicaid beyond the maternity cycle were included in the *Omnibus Budget Reconciliation Act (OBRA) of 1993*. When *OBRA 93* was signed into law in August 1993, midwives were recognized as providers of gynecology / women's health care under both Medicare and Medicaid.

As the Clinton health reform effort moved forward during the second session of the 103rd Congress there were discussions about how to assure competency of nurse practitioners. ANA took the position that defined APRNs as having a master's degree. With the exception of women's health NPs, most APRNs were in support of this position, but it was a problem for CNMs and those NPs who were still being educated in certificate programs. ACNM decided not to sign on to the ANA health reform evaluation paper, and this philosophical rift marked the beginning of discussions at ACNM to pursue solo Medicare reimbursement legislation.

In the end Republican opposition killed the Clinton health reform effort, and no legislation was passed. It was a bitter blow for APRNs who had seen this movement as the potential to expand practice through direct reimbursement. The midterm elections gave Republicans control of both the House and Senate, and the entire political landscape changed with the opening of the 104th Congress in 1995. When nurse practitioners began discussions about changing the bill to 85% reimbursement, ACNM decided to withdraw from the coalition and pursue its own legislative solution.

From the time that Senator Grassley and Congressman Towns introduced the *Primary Care Health Practitioner Incentive Act of 1995* with 85% reimbursement for NPs and CNSs, it took three years for NPs to achieve direct Medicare payment. The *1995 Omnibus Budget Reconciliation Act* included the NP Medicare provision and passed both House and Senate, but was ultimately vetoed by President Clinton for reasons other than the NP provision. President Clinton then included a provision for direct Medicare reimbursement for NPs and CNSs in the FY97 and FY98 budgets (released in February of 1996 and 1997). The *Primary Health Care Practitioner Incentive Act of 1997* was subsequently included in the *Balanced Budget Act of 1997* which was signed into law on August 5, 1997. For the first time NPs and CNSs were afforded direct reimbursement under Medicare at 85% of the physician fee schedule.

From this point on, the midwife effort took a radically different route than the nurse practitioner Medicare effort had taken. The first difference had to do with

the makeup of Congress. From 1995 through 2006 Congress was controlled by Republicans. Unlike the NPs who had forged a relationship with the Republican office of Senator Grassley, and ultimately passed their Medicare bill during a Republican Congress, CNMs continued to find their support in Democrat offices. The first solo CNM Medicare reimbursement bill, The *Certified Nurse Midwife Medicare Services Act of 1998*, was introduced in the second session of the Republican 105th Congress by a Democrat, Representative Towns. After another year of outreach looking for a Senate champion, Senator Kent Conrad (D-ND) introduced the *Promoting Access to Medicare Midwifery Services Act of 2000* in the Republican led 106th Congress. Through the next four Republican Congresses the midwifery Medicare effort was championed primarily by the Democrat Congressman Ed Towns and the Democrat Senator Kent Conrad and there was no movement on the bill. It wasn't until the Democrat controlled 110th Congress that the midwife legislation began to see action and was included in the House passed *Children's Health and Medicare Protection Act of 2007*. The 111th Congress was not only controlled by Democrats, but now there was a new Democrat President, and subsequently the midwife Medicare provision was passed as a part of the *Affordable Care Act* in 2010.

Over the years another significant difference in the midwife and nurse practitioner efforts was in the level of reimbursement the groups were willing to accept. When NPs decided to support a bill with 85% reimbursement in 1995, CNMs elected to pull out of that effort. During the three years that NPs worked to pass their 85% reimbursement bill, ACNM worked to replicate the Harvard RBRVS study

in order to determine how those physician rates should apply to midwives. When the study showed that the only difference from MDs was a slight variation in malpractice costs, ACNM began seeking sponsors who would support 97% reimbursement for midwives. The first solo midwife bill introduced in 1998 contained a compromise reimbursement of 95% because Representative Towns was unwilling to go with the 97% rate. The 95% reimbursement level prevailed until the 109th Congress in 2005 when the new lobbyist recommended raising the rate to 100%. When the 2006 elections gave Democrats a solid majority in the House and a split Senate, an SCHIP reauthorization bill called the *Children's Health and Medicare Protection Act of 2007* passed the House with the midwife 100% reimbursement piece included. However when the Senate passed their Medicare vehicle and pushed to have the midwife provision reduced to 85% in the conference bill, ACNM rejected this proposal. Midwives continued to hold to the 100% reimbursement level until it was included and passed as part of the Affordable Care Act in 2010.

Another important historical difference between the two groups was that during the six years of the NP effort to pass direct Medicare reimbursement, the only significant national agenda of note was the health reform effort that dominated the 103rd and 104th Congresses, led first by President Clinton and then taken up by the Republican 104th Congress. In contrast, the years between the resolution of the NP effort and the final passage of CNM Medicare equity were marked by two very

dramatic national events that changed the political landscape for those two Congresses.

The 107th Congress brought GW Bush to the Presidency, with a Republican House and a split Senate. Representative Towns and Upton (R-MI) introduced the *Certified Nurse Midwife Medicare Services Act of 2001*. ACNM brought 600 midwives to the Hill during their annual meeting, and there was hope that this might be the Congress to pass their legislation. But four months later on 9/11 everything changed politically. Senator Conrad never introduced the companion bill, and the remainder of the 107th Congress was focused on the aftermath of the terrorist attacks.

The 109th Congress could also have been a turning point for the midwife legislation. Representative Towns and Senator Conrad introduced the *Improving Access to Nurse-Midwife Care Act of 2005* early in the first session. ACNM once again held their annual meeting in DC again and sent 500 midwives to the Hill seeking cosponsors. However ACOG came out against the bill on the midwife lobby day, so summer 2005 efforts were spent doing damage control addressing the ACOG position. And then in September 2005 Katrina decimated the city of New Orleans and the Gulf Coast. The remainder of the 109th Congress was focused on recovery, repair and relief efforts for the people and areas that had been impacted by the storm.

The nurse practitioner Medicare reimbursement had passed on the heels of President Clinton's failed health reform effort, and the Republican Congress passage of their alternative *Health Insurance Portability and Accountability Act of 1996*

(*HIPPA*) health reform vehicle. Although the NP Medicare reimbursement provision was not included in *HIPPA*, it passed the following year as part of *OBRA 1997*. The midwife Medicare equity bill also saw resolution as part of another health reform effort. The 111th Congress began with a strong Democrat majority in both chambers of Congress, and the new Democrat President Obama who had an aggressive health reform agenda. Once again as during the Clinton health reform years, ACNM was part of a nursing coalition that promoted a health reform nursing agenda that included the midwife Medicare equity bill. ACOG, who was collaborating with ACNM on a women's health home provision for health reform, changed their previous opposition position and decided to support the midwife Medicare bill. The midwife Medicare bill was included in both the House and Senate health reform bills, and the *Patient Protection and Affordable Care Act*, with a provision granting 100% Medicare reimbursement for CNMs, was signed into law on March 23, 2010.

Fifteen years have passed since NPs were successful in achieving 85% reimbursement under Medicare. Nurse practitioners have had several bills introduced over the years, but none of them looking at Medicare reimbursement rates. The Medicaid reimbursement bill is still introduced each Congress, now by Senator Inouye and Congressman Olver. In addition, nurse practitioners have bills to allow reimbursement for providing home health care; to permit dispensation of certain narcotics for maintenance or detox without a separate license; and to sanction supervision of cardiac and pulmonary rehab programs. Many nurse practitioners thought that 85% would be a starting point that would give them

better visibility, and that they would be able to go back and get a more equitable payment later. Neither of those things has happened in 2012.

Comparison of Thematic Interview Analyses

The 14 midwife interviews and the 10 nurse practitioner interviews both utilized the same set of interview questions to discuss the two group's legislative efforts to achieve a level of Medicare reimbursement. For that reason it is not surprising that the same 6 categories were able to describe the 19 themes that were identified in both sets of interviews. Differences became modestly evident in the themes, and were significantly more apparent in the subthemes of the two cases.

Fifteen of the themes identified from the interviews were the same in both the midwife case and the nurse practitioner case. The other four themes in each case either represented a subtle difference or denoted a distinctly different premise. At the subtheme level the variances became more apparent. There were 29 subthemes in the CNM and 26 subthemes in the NP case. Thirteen of these subthemes were identical or very similar across the two cases. The other subthemes described concepts, characteristics or beliefs that were unique to one of the two cases.

The similarities and differences will be discussed for each of the six categories of themes. They are depicted in the following chart, and will be further illustrated in Venn diagrams for each of the six thematic categories.

Table 5: Thematic Analysis Comparison

Categories	Both Cases	CNM Case	NP Case
Policy Agenda	<p>Components of the Medicare bill</p> <p>Enactment of Medicare bill</p>	<p>Midwife Initial Inclusion in Medicare</p> <p>a. Why 65% to begin with</p> <p>b. Why 65% didn't work</p> <p>a. Changing provisions and titles</p> <p>b. Confusing rationale for reimbursement percentages</p> <p>Cost of Medicare equity bill</p>	<p>Direct Medicare reimbursement for NPs</p> <p>a. Early efforts at direct reimbursement</p> <p>b. Why direct payment was important</p> <p>c. 85% reimbursement</p> <p>d. Other reimbursement percentages</p> <p>e. Other components of the bill</p>

Categories	Both Cases	CNM Case	NP Case
Politics and the Political Process	<p>The political process</p> <p>a. Congressional impact on the process</p> <p>What it takes to pass a bill</p> <p>a. Importance of cost analysis and scoring</p> <p>b. Importance of timing</p> <p>Politics</p> <p>a. Party Politics</p> <p>b. Political Climate</p> <p>Emotions experienced during the process</p>	<p>b. How the legislative process works</p> <p>c. How long the process takes</p> <p>c. Importance of a vehicle</p> <p>Political Porters</p> <p>a. Importance of choosing the right sponsors</p> <p>b. Political connections</p>	<p>d. Engaging in the legislative process</p> <p>Political Support and Opposition</p> <p>a. Political porters</p> <p>b. Political adversaries</p>
Relationships	<p>Relationships with nursing</p> <p>Relationships with MDs</p>		<p>Relationships among NP organizations</p>

<i>Categories</i>	<i>Both Cases</i>	<i>CNM Case</i>	<i>NP Case</i>
Organizational Capacity	<p>Organizational Resources</p> <p>Organizational Leadership and Management</p> <p>a. Contributions of volunteer leadership/volunteers and leadership</p> <p>Individual and collective midwives/nurses and nurse practitioners</p> <p>a. Personality characteristics that impact political advocacy</p> <p>b. How CNMs/NPs are perceived/branding</p>	<p>a. Small size of organization</p> <p>b. Amount of money for political advocacy</p> <p>b. National office issues</p> <p>c. Lobbyist effectiveness</p> <p>d. Elected leadership of the college</p>	<p>c. Size and appearances</p> <p>d. Money and resources</p> <p>e. Professional lobbyist and PAC</p> <p>f. Competing issues</p>

Categories	Both Cases	CNM Case	NP Case
Political Competence	<p>Organizational strengths</p> <p>a. Persistence/ Persistent laser focus on issue</p> <p>b. Engaging NPs/ members and leadership in grassroots political advocacy</p> <p>c. Evolving political sophistication</p> <p>Organizational weaknesses</p> <p>a. Inconsistent and inadequate strategy development</p> <p>b. Inadequate coalition building</p>	<p>c. Poor messaging of decisions, issues and accomplishments</p> <p>d. Not enough presence in DC</p>	<p>e. Not enough collection or distribution of NP data</p>
Gender	<p>Gender impacts political capabilities</p> <p>Gender impacts political reception</p>	<p>Gender of the care recipients</p>	<p>Harnessing the power of gender</p>

Policy Agenda Issues

Both Kingdon and Longest speak about the process of agenda setting where political problems are matched with possible legislative solutions (Kingdon, 1995; Longest, 2010). Policy Agenda in these two cases refers to the problems

surrounding Medicare reimbursement for midwives and nurse practitioners, the possible solutions to address those problems, and early efforts to resolve the payment problem.

All 14 midwife case participants and all 10 nurse practitioner case participants spoke about Policy Agenda issues. There were 4 themes and 4 subthemes identified in the CNM case; 3 themes and 5 subthemes detected in the NP case. Two of the themes were the same for both cases, but none of the subthemes were expressed by both CNMs and NPs. The following diagram shows the unique and shared themes and subthemes for the two groups (Figure 8).

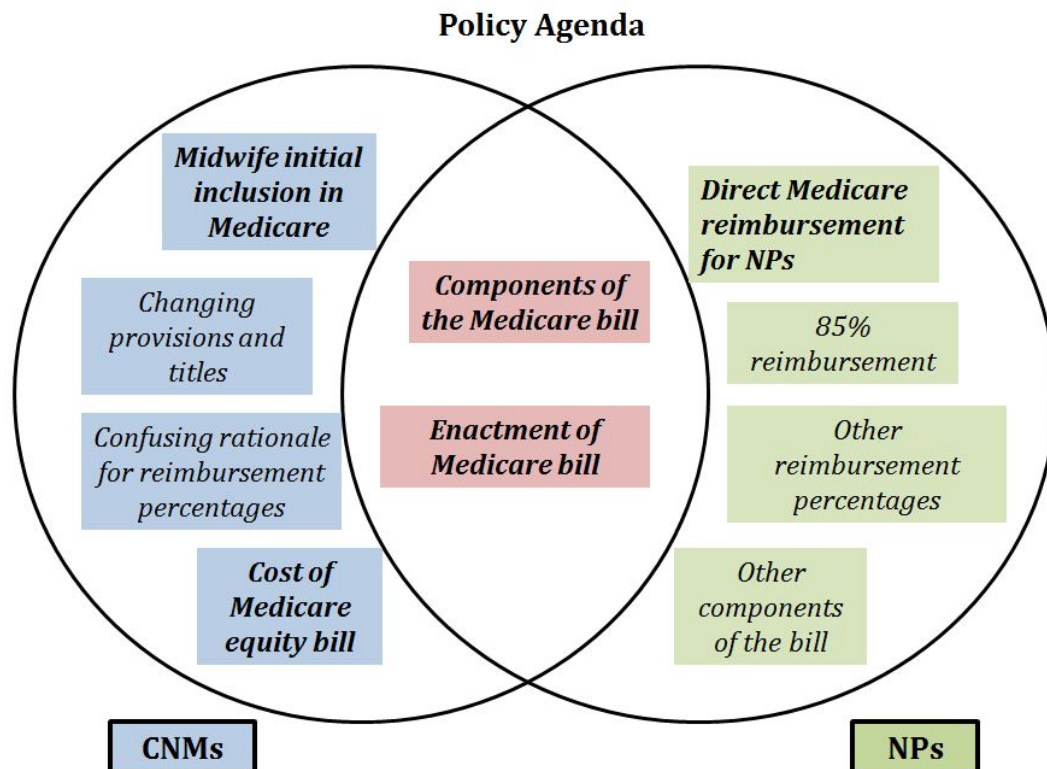


Figure 8: Policy Agenda Thematic Diagram

Seven midwife case participants spoke about the *midwife initial inclusion in Medicare*, and within that theme focused on *why 65% to begin with*, and *why 65% didn't work*. Nurse practitioners, with the exception of those who worked in rural practices, were not able to bill directly for Medicare reimbursement at the onset of the case. So nine NP case participants spoke about *direct Medicare reimbursement for NPs*, specifically about their *early efforts at direct reimbursement*, and *why direct payment was important*.

The strongest common theme in the Policy Agenda category was the ***components of the Medicare bill***. Thirteen CNM case respondents and all ten NP case respondents spoke about this theme, but the subthemes identified were different for each group. Midwife case participants spoke about *changing provisions and titles* in their Medicare bill, and the fact that there was *confusing rationale for reimbursement percentages* that changed across the lifespan of the effort. NP case participants talked about how and why the *85% reimbursement* was included in the bill, what had been the discussion around *other reimbursement percentages*, and what the *other components of the bill* included (such as definitions and professional requirements).

There was one smaller theme that was identified in both cases. Four NP and three CNM/CM participants spoke about ***enactment of the Medicare bill*** and how it has played out for their professions. Additionally there was one theme that was unique to the midwife case. Four midwife respondents talked about the ***cost of Medicare equity bill***, which they reported as being negligible and therefore a positive determinant in finally passing the legislation. It should be noted that this was different than cost analysis discussions in the Politics and Political Process section.

Politics and the Political Process

According to Kingdon and Longest there is a third stream in the policy agenda setting process. The political stream occurs independently of the problems

and solutions and defines the political climate in which policy formation occurs (Kingdon, 1995; Longest, 2010). The second category of themes takes into account this political stream as well as the specific legislative processes that must occur in order for policy to be formulated and passed into law.

All fourteen CNM/CM participants and all ten NP case participants spoke about Politics and the Political Process. There were four themes and five subthemes shared by the two cases. Midwives spoke about one solo theme and five unique subthemes. Nurse practitioners had one solo theme and three unique subthemes. The unique and shared themes and subthemes for the CNMs and NPs are illustrated in the following Venn diagram (Figure 9).

Politics and the Political Process

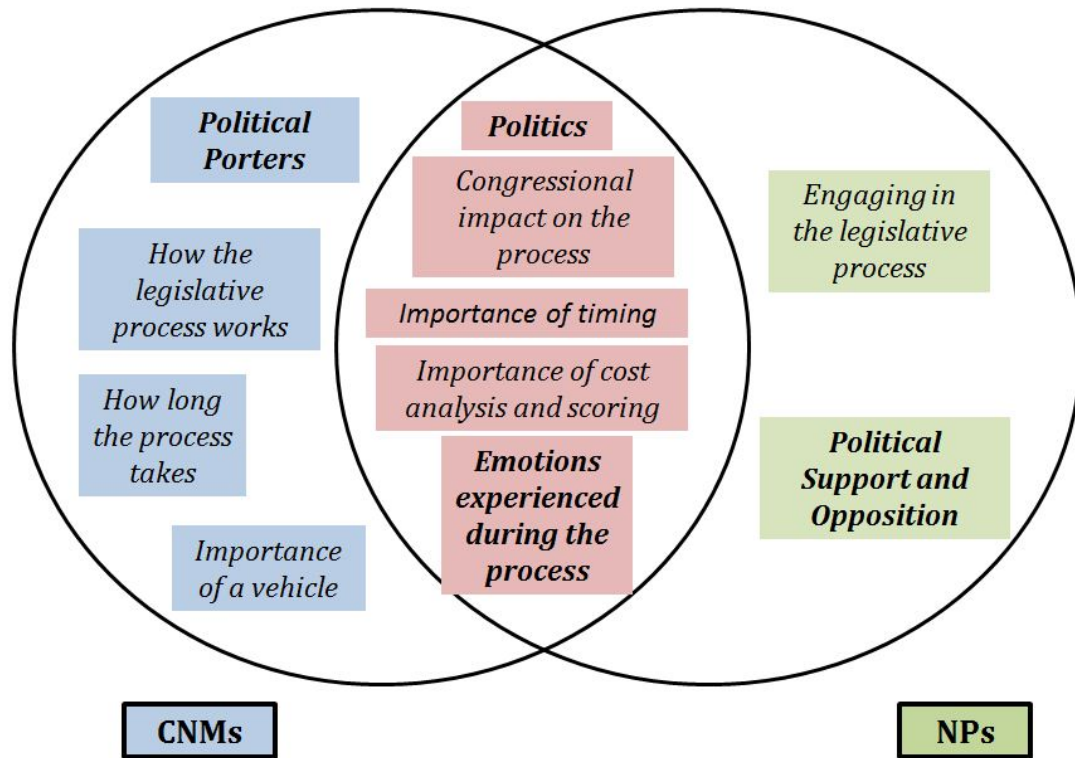


Figure 9: Politics and the Political Process Thematic Diagram

Ten CNM case participants and six NP participants spoke about *the political process*, and interviewees in both cases felt that *congressional impact on the process* was important. Midwife participants also spoke about two distinct subthemes: *how the legislative process works*, and *how long the process takes*. Respondents from the nurse practitioner case, which had only lasted six years, instead spoke about how NPs had been *engaging in the legislative process* as their bill progressed to passage.

The largest common theme identified for the two cases was *what it takes to pass a bill*. Twelve participants from the midwife case and seven from the nurse

practitioner case spoke about this theme, and there were two subthemes that they both identified. Both CNMs and NPs spoke about the *importance of cost analysis and scoring*, and the *importance of timing* in getting legislation to be acted on. Midwives additionally identified the *importance of a vehicle* in passing smaller issue legislation.

Another common theme across the two cases was ***politics***. Eleven midwife respondents and five nurse practitioner respondents spoke about this theme, and two subthemes were also identified by both groups. CNMs and NPs both talked about *party politics*, citing partisan stalemate in Congress and the importance of being seen as non-partisan in order to get bipartisan support. Both groups also believed that the *political climate* impacted the progress of their efforts.

There were two themes that were unique, one to each case. Five midwife case participants spoke about the impact of ***political porters*** on the process and outcome, and identified two subthemes: *the importance of choosing the right sponsors*, and the impact of making *political connections*. A related but slightly different theme was identified by seven NP case participants who cited the impact of ***political support and opposition***. NPs stated that they had been helped by *political porters* but hurt by unexpected *political adversaries*.

Finally, a smaller theme that was common to both cases was the ***emotions experienced during the process***. Three participants from the midwife case and three participants from the nurse practitioner case spoke about this theme and

noted that there were highs and lows experienced while engaging in the political process.

Relationships

A significant factor in the political arena is the relationship with other special interest groups and their input into the political process. Feldstein contends that health professional associations, acting as special interest groups, get involved in the political process to protect the economic needs of their members. This can take the form of policy that will increase usage of their members' professional expertise and facilitate the highest possible payment for their member's services, or if necessary restrain competition by other professionals who offer comparable services (Feldstein, 2006). The third category of themes discusses relationships within the health policy arena.

Twelve of the fourteen midwife case participants and nine of the ten nurse practitioner case participants spoke about Relationships. Two of the three themes in this category were shared between both cases. Nurse practitioners discussed one theme that was unique to their case. There were no subthemes identified in this category. The following diagram shows the unique and shared themes and subthemes for the two groups (Figure 10).

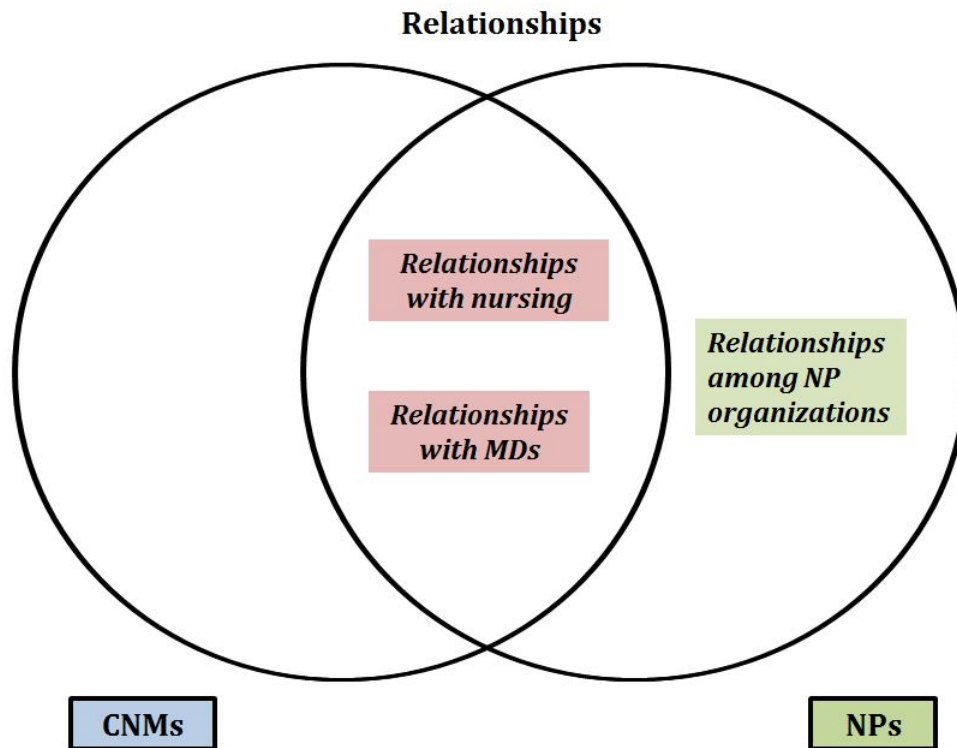


Figure 10: Relationships Thematic Diagram

Nine midwife and eight nurse practitioner participants spoke about *relationships with nursing*. For CNMs this theme included relationships with the entire nursing and NP community, and expressed a range of sentiments from CNMs desiring independence from nursing to a belief that CNMs would be stronger if they learned to accept their differences and work together with RNs. For the NPs this theme included beliefs that nursing had not been supportive of the early NP movement and conflicting attitudes over who can and should speak for NPs.

Eight respondents from the midwife case and seven from the nurse practitioner case spoke about *relationships with physicians*. This theme included comments about physician autonomy in the health care arena and physician opposition to the Medicare reimbursement efforts. It should be noted the while there was never a reference to physician support in the NP case, CNMs did note that last minute support from OB/Gyns was important to the final outcome of their legislative effort.

There was one theme that only came up in the nurse practitioner interviews. Throughout most of the midwife effort ACNM had been the sole organization working for midwife Medicare equity. In contrast, nurse practitioners had always been actively represented by ANA, one or two generic national NP organizations, and several specialty NP organizations. Therefore it is not surprising that eight NP participants spoke about *relationships among NP organizations*. Almost universally they recognized that the confusion of multiple professional organizations had been a problem in their legislative effort.

Organizational Capacity

In Feldstein's economic version of the interest group theoretical scenario, organized interest groups make decisions to engage in policy based on the perceived costs of organizing and providing political support versus the potential benefits of a legislative solution (Feldstein, 2006). The fourth category of themes

takes into account the capacity of the special interest groups to engage, including their size and resources, management capabilities and membership abilities.

All fourteen interviewees from the midwife case and all ten from the nurse practitioner case spoke about Organizational Capacity issues. There were three themes identified, and all three were common to both cases. Three shared subthemes were also found in both cases, but there were five unique subthemes to the CNM case and four unique subthemes to the NP case. The unique and shared themes and subthemes for the CNMs and NPs are illustrated in the following Venn diagram.

Organizational Capacity

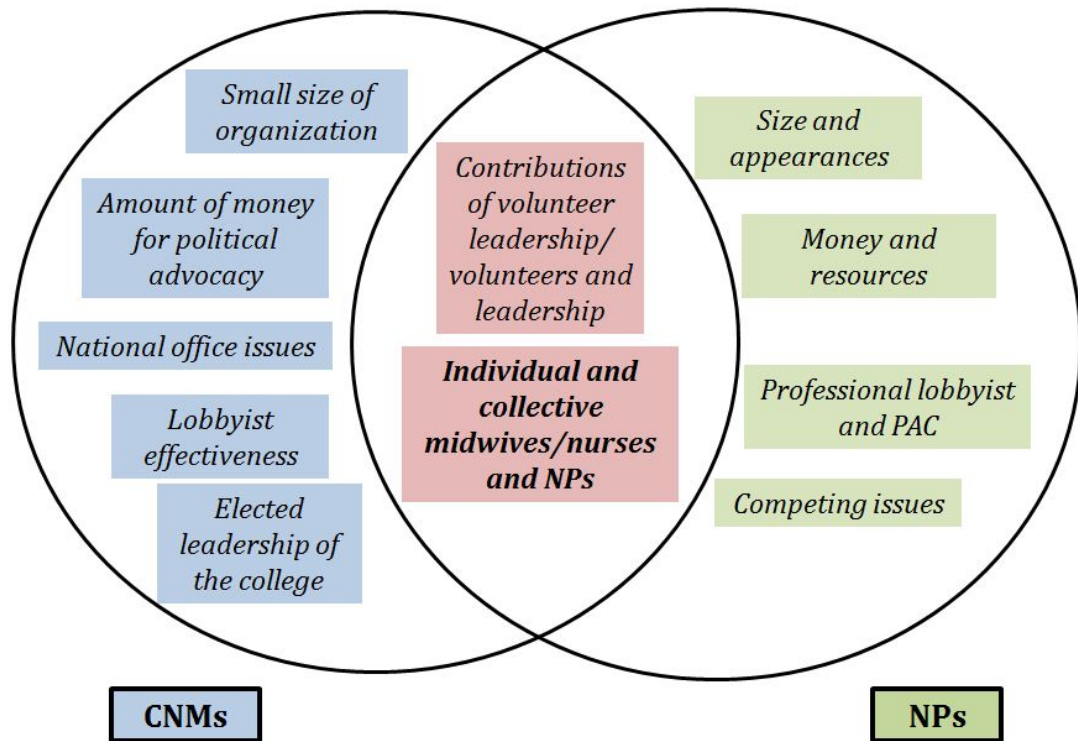


Figure 11: Organizational Capacity Thematic Diagram

Fourteen midwife case participants and seven nurse practitioner participants spoke about **organizational resources**. There were two subthemes identified by each group that were similar but unique to each case. CNM case respondents talked about the *small size of the organization* which was responsible for its lack of political clout. They also identified that ACNM never had the *amount of money for political advocacy* that other, larger organizations had. Participants from the NP case talked about *size and appearances* also, but their comments included both the small number of NPs who belonged to many organizations, and of the larger and more

powerful ANA. They also identified *money and resources* as being lacking in some organizations and abundant in ANA.

The second theme in the Organizational Capacity category was ***organizational leadership and management***. Every midwife participant and every nurse practitioner participant spoke about this theme, and there was one shared subtheme, the *contributions of volunteer leadership/volunteers and leadership*. Participants in each organization could point to very specific passionate and dedicated volunteers who had major impacts on the group's efforts. There were three unique subthemes identified by the CNM case participants. They spoke about *national office issues* including staff compatibility, leadership effectiveness and changes, and the visibility of the organization in the political arena. They discussed the *lobbyist effectiveness* of the two ACNM lobbyists during the nineteen year effort. And they spoke about the policy efforts of the *elected leadership of the college*. In contrast, NP case participants did not speak about their leadership or national office issues. They did speak in general about the importance of having a *professional lobbyist and PAC* to make the profession more able to compete in the political arena, and noted that ANA had both of those resources. They also spoke about the *competing issues* within Medicare that have kept NPs from revisiting the 85% reimbursement in favor of a higher rate.

Finally, all fourteen midwife case participants and nine of the ten nurse practitioner participants spoke about ***individual and collective midwives / nurses and nurse practitioners***. There were two subthemes identified that were also

common to the two groups. Participants in both the CNM and NP cases talked about *personality characteristics that impact political advocacy*, including not being able to find time for advocacy in their busy profession, and fear of rocking the boat. They also jointly spoke about *how midwives / NPs are perceived / branding*. There was a strong consensus that CNMs / NPs needed to do a better job of promoting an understanding of what the professional does, why there is a need for them, and how what they offer is different than a physician.

Political Competency

Secondary to possessing the capacity to engage in political activity is having the competence to make use of one's resources. The fifth category of themes was entitled Political Competency, and took into account what the different groups did well and what they did poorly in their political efforts to achieve equitable Medicare reimbursement.

All fourteen midwife respondents and all ten nurse practitioner respondents spoke about Political Competency. There were two themes that were evident in both cases: *organizational strengths* and *organizational weaknesses*. Additionally there were eight subthemes identified: five were common to both cases, two were reported by CNM/CM participants, and one was unique to the NP case. The following diagram shows the unique and shared themes and subthemes for the two groups.

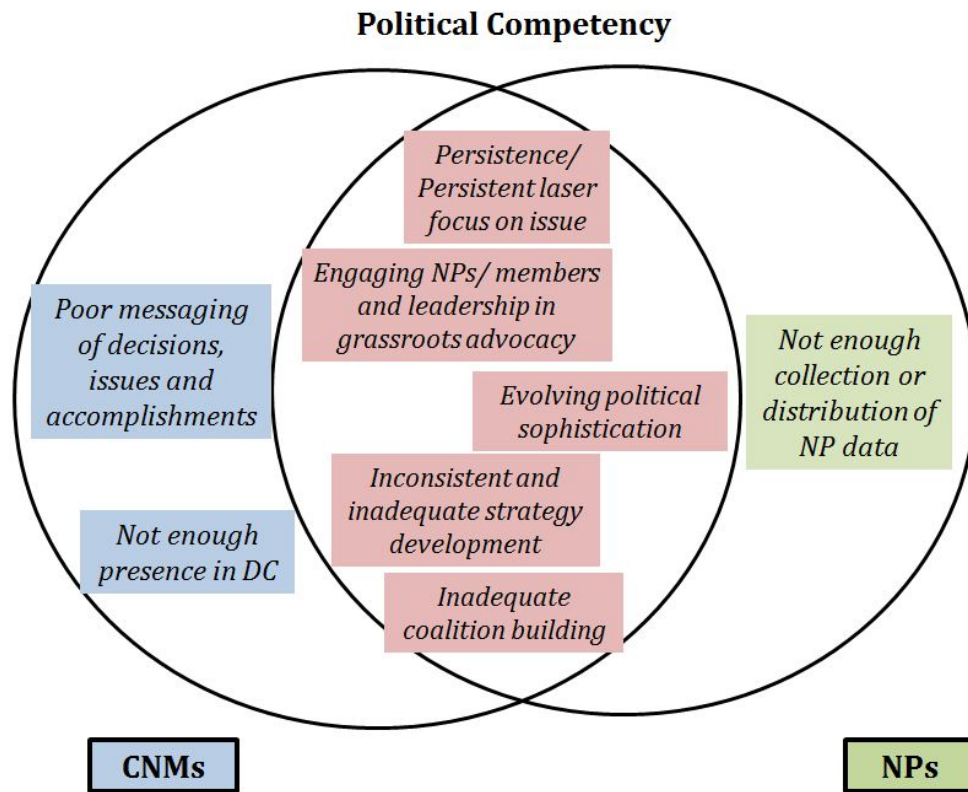


Figure 12: Political Competency Thematic Diagram

All respondents in both the midwife case and the nurse practitioner case spoke about **organizational strengths**. The three main strengths that were identified as subthemes were noted by respondents in both cases: *persistence/persistent laser focus on issue, engaging NPs/members and leadership in grassroots political advocacy, and evolving political sophistication*. Both CNM and NP case participants believed that inherent in the *evolving political sophistication* of their organizations was the growth from being very reactionary to what was happening in the policy arena into a more proactive approach to policy involvement.

Nine midwife participants and nine nurse practitioner participants identified ***organizational weaknesses*** in this category. There were five subthemes identified, two of which were identified by both groups. Both CNM and NP respondents spoke about *inconsistent and inadequate strategy development* over the course of the policy effort, although both reported significant improvement during the final years (midwives) or year (NPs) up to passage of the legislation. The interviewees in both the CNM and NP case also stated that there had been *inadequate coalition building* during the policy effort, and felt that they might have fared better if they had collaborated more with nurses and other APRNs. There were two subthemes that were unique to the CNM case. CNM respondents felt that there had been *poor messaging of decisions, issues and accomplishments*, and that there had been *not enough presence in DC* with midwives for advocacy efforts. The one subtheme that was only reported by the NP case participants was *not enough collection or distribution of NP data* that could have helped to raise the visibility and credibility of the profession with policymakers.

Gender Issues

According to Bryson, politics and gender are inseparable, but existing political concepts and values have not traditionally included feminist viewpoints (Bryson, 1992). Although Gender Issues could potentially have fit into one or more of the other categories, it was decided to isolate them into a separate category in order to better analyze their impact on these cases.

Each of the fourteen midwife and ten nurse practitioner participants spoke about Gender Issues. There were four themes identified. Two themes were shared by both CNM and NP cases. One theme was unique to the CNM case and one was unique to the NP case. There were no subthemes identified in the Gender Issues category. The unique and shared themes and subthemes for the CNMs and NPs are illustrated in the following Venn diagram (Figure 13).

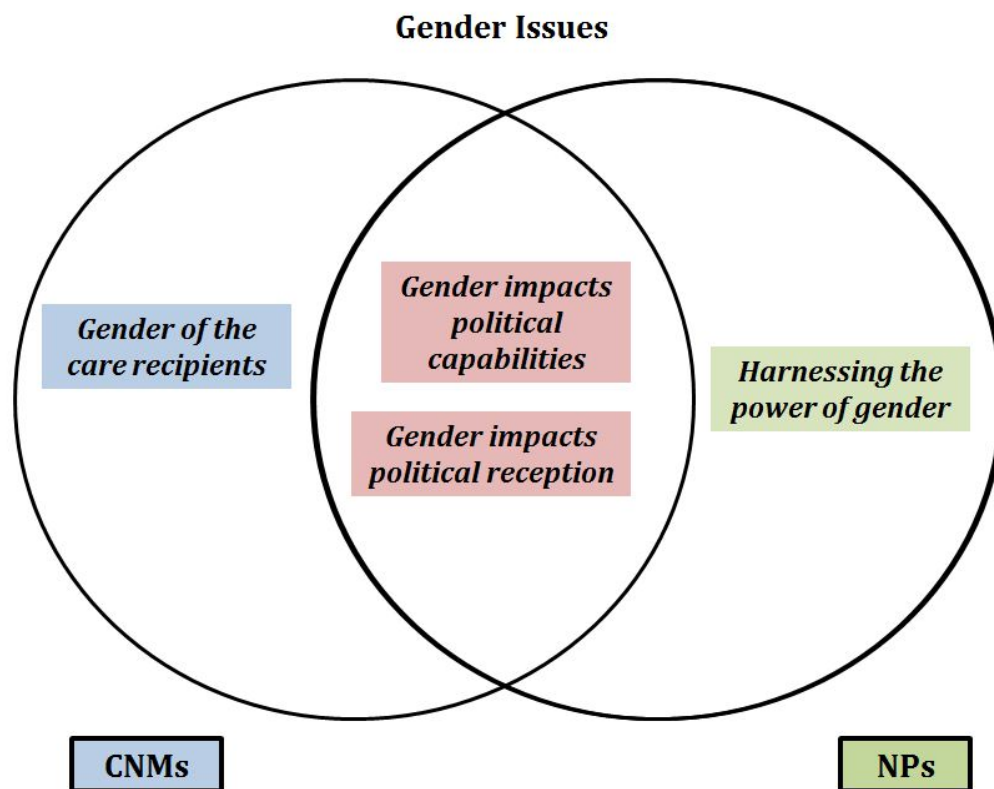


Figure 13: Gender Issues Thematic Diagram

Nine participants in the midwife case and nine in the nurse practitioner case discussed how ***gender impacts political capabilities***. Both sets of participants believed that women are not inherently drawn to political advocacy but can be taught to be effective advocates. They also both believed that gender might offer an advantage in making connections. The NP case respondents talked about men in the nursing profession as political advocates, but a few believed that political effectiveness was a personality trait that was not unique to men or women.

Eleven midwife participants and seven nurse practitioner participants spoke about how ***gender impacts political reception***. Within the CNM case there were interesting trends in how this was expressed. The two younger participants along with the male participant believed that there was no difference in how policymakers respond to women versus men. However the other eight CNM/CM participants adamantly believed that women were not taken seriously by policymakers. In the NP case there was more of a sense that Congress was a male model thinking body that traditionally hadn't taken women seriously, but that some male legislators had taken almost a paternal interest in helping NPs.

The theme that was unique to the midwife case was the ***gender of the care recipients***. While most nurse practitioners take care of children and families, midwives exclusively care for women. Eleven midwife case participants spoke about how the ***gender of the care recipients*** made it doubly hard to get legislators' attention. They believed that women's issues don't matter as much to policymakers,

and that there has been and remains a constant struggle in Congress to protect women's health.

The final theme in the Gender Issues category was unique to the nurse practitioner case. Seven participants in the NP case spoke about ***harnessing the power of gender***. The respondents felt gender was what helped PAs get ahead faster, and that men entering the NP profession had made a difference in the collective business and political savvy of the organizations. They believed that some legislators bond with men and some with women so it is good to have both as part of an advocacy effort.

Midwife and Nurse Practitioner Comparative Case Analyses

This dissertation opened by asking why CNMs and NPs fared so differently in their quests to achieve Medicare payment equity. In this section I will use the historical narratives and thematic analyses to first discuss why the process length of time was so much longer for the CNMs than for the NPs. Next I will address the different reimbursement rate outcomes for the two groups based on the findings from the two cases. Finally I will use the comparative thematic analyses to assess whether Bryson's feminist political theory and Feldstein's economic version of the interest group theory can be validated by these two political efforts.

Process Length of Time

When nurse practitioners and midwives first set out on a Medicare equity quest in 1991, they were not starting from an equal position. NPs had been seeking

direct payment under Medicare since the first bill had been introduced by Senator Inouye in 1974. The bills that had been introduced by Inouye, Roybal and Markey over the ensuing 17 years had never specified a percentage of reimbursement, so in that light the 1991 Grassley bill asking for 97% could be described as a new legislative effort for NPs. But in reality the 97% Grassley bill was a modification of an effort that had been going on for 17 years. Nurse practitioners were still attempting to gain direct Medicare reimbursement, and they were specifying a desired level of reimbursement.

On the other hand, CNMs had begun their efforts for direct Medicare reimbursement in 1977 when Senator Inouye introduced their first bill, but they had succeeded in achieving direct payment under Medicare with the passage of OBRA 1987. So for CNMs the 1991 Grassley bill seeking 97% reimbursement was a new legislative effort. Midwives were attempting to raise the direct reimbursement rate under Medicare from 65% to 97%.

From 1991 until 1994 CNMs and NPs worked in coalition with CNSs to promote the 97% Medicare legislation. After a rocky start with ANA not supporting the request for 97% in the 102nd Congress, they got fully behind the bill in the 103rd Congress that began in 1993. That was the same year that brought the new Democrat President Clinton to the White House with an aggressive agenda of health reform. The country was experiencing a shortage of primary care health providers, and with both a Democrat Congress and a Democrat President who was committed

to working with nurses, the stars were seemingly aligned for the NPs and CNMs to be able to move their legislation.

Two things happened towards the end of 1994 that altered the outcome for nurse practitioners and midwives: the Clinton health reform effort failed, and Republicans took control of both the House and Senate in the midterm elections. Senator Grassley was a Republican, and he was committed to getting the Medicare bill passed, but not necessarily to the 97% rate. When the 104th Congress opened in 1995 Grassley pushed to modify the Medicare bill to 85% reimbursement, and midwives elected to separate from the effort.

Two years later, during the 1st session of the 105th Congress, the NP 85% direct reimbursement bill passed as part of the *OBRA 1997*. It had been six years since the Medicare bill had been first introduced, seemingly a success story. But if you take into account the entire legislative history of the NP quest for direct Medicare payment, then it becomes a 23 year legislative effort and a very different picture.

Had ACNM not separated from the NP effort in 1995 they would have seen resolution of the effort with the NPs in the 105th Congress, a short six years from the original bill introduction. However two things happened when ACNM decided to break with the NPs. First, midwives' decision not to accept 85% angered some House and Senate members who believed midwives were being unreasonable. And secondly, midwives did not message this decision well to nurses and nurse

practitioners, and so they did not have the full support of those groups as they attempted to move forward on their own.

From the time the first solo midwife bill was introduced during the 105th Congress in 1998 until passage of the midwife Medicare equity bill as part of the *Affordable Care Act* in 2010, twelve years and six Congresses elapsed. In total, nineteen years and ten Congresses elapsed between the original Grassley bill introduction and final resolution of the midwife effort. There is no single answer as to why it took this amount of time for midwives to pass their legislation. Some of the reasons will be discussed in the analysis of the two hypothesized theoretical frameworks. But several factors that are outside of those theories bear some discussion.

First, it is critical to place the passage of the two bills within their historical context. The NP Medicare reimbursement bill passed shortly after an aggressive health reform effort by a Democrat President. The next time there was a health reform effort was during the next Democrat Presidency, and that is when the midwife Medicare bill passed. Clearly the health consciousness raising that takes place during a health reform effort is a positive factor for expansion of APRN practice.

Looking back at midwifery policy history it is apparent that midwives have always fared better when Democrats controlled the House and Senate. The first time midwives were named in a federal statute was in 1977 when they won reimbursement under CHAMPUS. That 95th Congress was controlled by Democrats

and there was a Democrat in the White House (Carter). Three years later *OBRA 1980* included a Mikulski/Inouye amendment to reimburse Midwives under Medicaid. That was during the Democrat led 96th Congress and Carter was still President. *OBRA 1987* gave midwives direct reimbursement under Medicare. This time there was a moderate Republican in the White House (Reagan) but Democrats controlled the 100th Congress. The last midwife legislative payment victory before 2010 was when *OBRA 1993* extended Medicare and Medicaid payment for CNMs beyond the maternity cycle. That was during the Democrat controlled 103rd Congress, and a Democrat President was back in the White House (Clinton). The 103rd Congress was the last time that Democrats were in control of both chambers until the 111th Congress in 2009 which also brought a Democrat back to the White House (Obama).

In addition to the historical rationalizations, there were also some internal competency issues that came to light during the interviews. ACNM suffered from an inconsistent and inadequate strategy about how to move the bill. This was partially due to differences in lobbyist styles, and to the derailment of the effort when the first lobbyist became ill. Some of the inconsistency may have had to do with changing organizational priorities due to leadership turnover. But there were also participants that felt ACNM just didn't have a clearly articulated strategy to move their bill forward (Pages 182-183).

Next, ACNM did not do a good job throughout those 12 years of forming coalitions and mobilizing its consumers. When CNMs worked with NPs and CNSs in the early years they were able to get traction on the bill, and when they worked

together in a nursing coalition during health reform they were again very successful. But in between they tried for the most part to go it alone. Other smaller organizations made up for their size by mobilizing their consumers, but ACNM for some reason always seemed to resist this (Pages 184-185).

Finally, midwives have never had enough presence in the halls of Congress. Early in the process ACNM held yearly legislative conferences that would bring about 100 members to the Hill to lobby for the midwife Medicare equity bill. When the organization has had its annual meetings in DC there has been a surge of activity in getting cosponsorships. And when there was a policy intern for six months, who lobbied every week on the Hill for the legislation, it got its most ever number of cosponsors. Additionally, other similar professional organizations hold yearly conferences in DC so that they can bring their members to the Hill to lobby. ACNM, however, has elected not to follow that example and therefore has not had the same visibility with policymakers (Page 185).

Process Outcome

When midwives and nurse practitioners began their joint quest for equitable Medicare reimbursement they originally asked for 97% of the physician fee schedule. This value was not based on a study of the relative value of CNMs and NPs with physicians. Rather it was chosen because at the time malpractice was 4% of the relative value scale that determined physician fees. CNMs and NPs made the determination that malpractice was the only difference in their overhead from

physicians, so after much discussion among themselves they chose to ask for 3% less than physicians were receiving.

In 1995 NPs agreed to a modification of the Medicare bill setting the reimbursement rate at 85%. Midwives decided at that time to separate and pursue solo legislation. There was some confusion about where the 85% value had come from. Some NPs thought it had been an arbitrary value, but a few pointed to the fact that the PAs were getting 85%. Regardless of its origin, the 85% made the bill score in a range that was acceptable to policymakers. It made nurse practitioners appear to be the discount or cost effective providers, and that was enough to move the bill in a Republican Congress. Nurse practitioners ended up with 85% precisely because they were willing to compromise and accept that rate. For NPs, who had no direct reimbursement prior to the passage of the Grassley bill, 85% was better than nothing, and it was 20% better than CNMs were getting at that point.

For midwives, the struggle for Medicare equity continued 12 years beyond the nurse practitioner resolution. Over the years of the Medicare equity quest several different percentages were either discussed or requested in the legislation. Midwives had turned down 85% when the nurse practitioners agreed to accept that rate. This percentage was pushed again during the 110th Congress when the equally divided Senate was negotiating a Medicare package with the Democratic House. But once again ACNM elected not to take the 85%, and thereby lost a chance to be included in that year's final Medicare bill.

Between 1998 and 2006 the midwife Medicare bill asked for 95% reimbursement. This the result of a compromise with the bill sponsors. In 1997 ACNM had replicated the Harvard study that had developed the resource based relative value scale (RBRVS) used for determining the physician fees. Because that study had shown the only difference between MDs and CNMs was a slight variation in malpractice costs, the ACNM BOD had committed to seeking 97% reimbursement, however bill sponsors felt this was not appropriate since NPs had just received 85%.

When the midwife Medicare bill was reintroduced during the 109th Congress in 2005 the reimbursement percentage was set at 100%. This was a result of the new lobbyist having convinced both ACNM and the bill sponsors that not only was 100% more equitable, it was also more arguable. This same percentage was included in the *Affordable Care Act* and was signed into law in 2010. And while there is no crystal ball that explains how ACNM was able to achieve that final 100% reimbursement level, two factors likely had a lot to do with the organization's success.

The first factor was the obvious perfect storm that emerged with health reform. The *Affordable Care Act* was the perfect vehicle to attach a midwife payment provision, and the entire process of health reform had considerably raised the awareness on the part of policymakers about midwives and other non-physician providers. Also, given the large size and cost of the *Affordable Care Act*, a small provision like the midwife Medicare equity could easily be included without adding much cost or consequence.

The second reason for the organization's success was the fact that midwives started this quest at 65% and always believed that they deserved full equity. And while 85% is better than 65%, it was never what the members thought they deserved, or what the replication of the Harvard RBRVS study told them they deserved. Having turned that percentage down once when they broke with NPs in 1995, it was more of a visceral reaction to turn it down a second time in 2007. By then 85% felt personally insulting, rather than just being a political compromise (Page 151). That being said, midwives probably would have ended up with 95% during health reform had they not had five years of convincing lawmakers that they deserved equal pay for equal work. When the new lobbyist convinced both ACNM and the bill sponsors to seek 100% reimbursement, that decision changed the policy history and set up the eventual inclusion of 100% in the *Affordable Care Act*.

The Role of Gender Politics

In the first chapter of this dissertation I postulated that feminist political theory framed the struggle for midwife and nurse practitioner payment equity as something larger than just the political process, and offered a different way of understanding the political efforts of two predominantly women's special interest groups to achieve payment equity. The following chart summarizes the three primary themes in Bryson's feminist political theory, and demonstrates how patterns (themes) identified in the CNM and NP case interviews correspond with those three central themes:

Table 6: Role of Bryson’s Feminist Political Theory in Medicare Reimbursement Efforts

Bryson’s Feminist Political Theory Themes	CNM and NP Shared Themes	Midwife Themes	Nurse Practitioner Themes
<p><i>Political actions are inseparable from the personal domain; the political is personal and the personal is political</i></p>	<p><i>Gender impacts political capabilities</i></p> <ul style="list-style-type: none"> a. Women are better at making political connections b. Women lack skills necessary for advocacy 	<p><i>Gender of the care recipients</i></p> <ul style="list-style-type: none"> a. Women’s issues have very low priority for policymakers b. Policymakers’ interference in personal areas of women’s health 	<ul style="list-style-type: none"> c. personality traits for good political advocacy found in either gender, but probably less common among nurses
<p><i>Existing political concepts and values need to be restructured to include feminist viewpoints</i></p>	<p><i>Gender impacts political reception</i></p> <ul style="list-style-type: none"> a. Women are not taken as seriously by policymakers 	<ul style="list-style-type: none"> b. Women are better accepted by young legislative staff <p><i>Gender of the care recipients</i></p> <ul style="list-style-type: none"> a. Policy makers more disposed to legislate about disease b. feminist restructuring of existing political concepts = transition to paradigm where healthy moms and babies are political priority 	<ul style="list-style-type: none"> c. Some male legislators take a paternal interest in helping NPs

Bryson's Feminist Political Theory Themes	CNM and NP Shared Themes	Midwife Themes	Nurse Practitioner Themes
<i>The privilege men enjoy because of existing gender inequalities, and potentially the entire capitalistic economic system, should be reevaluated with these new viewpoints</i>			<i>Harnessing the power of gender</i> <ol style="list-style-type: none"> a. Men entering the NP profession made a difference b. Gender may have been tipping point as to why NPs got 85% instead of 97%,

According to feminist political theory, the political is personal and the personal is political. Two of the themes identified in the Gender interviews could potentially overlap with this statement. The first theme in the Gender category was the participants' view that *gender impacts political capabilities*. However, the participants saw this impact through very distinct lenses. The two younger interviewees and the male participant in the midwife case believed that the personal attribute of being female made women better at making the connections necessary for political advocacy, while all the other midwife case interviewees thought their gender made them less effective because they lacked the skills necessary to advocate in the political arena (Pages 186-187). The nurse practitioner case participants were split between the two viewpoints, and additionally offered that the personality traits that make for good political advocacy could be found in either gender, but were probably less common among nurses (Pages 242-243). Either way,

the personal attribute of being female is part of the political response, for better or worse.

The second theme that could potentially match with “the political is personal” is the *gender of the care recipients*. This was a theme unique to the midwife case. Participants believed that women’s issues have very low priority for policymakers. At the same time they complained about policymakers’ interference in personal areas of women’s health (Pages 188-190). These two issues make policy very much a personal issue for both the predominantly female midwives and the women that they care for.

Feminist political theory’s second premise, that existing political concepts and values need to be restructured to include feminist viewpoints, matches well with the second theme identified in the interviews. According to the participants in both cases, *gender impacts political reception*. Younger participants in the CNM case believed that women are better accepted by young legislative staff, while older midwife participants thought that women are not taken as seriously by policymakers, but agreed that as more and more women join the ranks of congressional staff this is changing (Pages 187-188). The NP case participants who discussed political reception viewed Congress as a male model thinking body that traditionally hadn’t taken women seriously, but noted that some male legislators had taken almost a paternal interest in helping NPs (Pages 243-244).

One other theme from the interviews intersects with this second premise. Part of the discussion around the *gender of the care recipients* was that maternity

care has never received much political attention from policy makers who seem more disposed to legislate about disease (Pages 188-190). It would then follow that part of the feminist restructuring of existing political concepts and values would be a transition to a wellness focused paradigm where healthy mothers and babies would be a political priority.

The final premise in feminist political theory is the economic privilege that men enjoy because of existing gender equalities. There was no strong match to this theme in the midwife interviews. Participants spoke of the male dominance of medicine compared to the female dominance of nursing and midwifery, but when they discussed payment inequality it was more in regards the differences between how physicians and midwives are compensated (Pages 163, 172-173). Nurse practitioners spoke about *harnessing the power of gender*. They believed that gender was what helped PAs get ahead faster, and that men entering the NP profession had made a difference in the collective business and policy savvy of the organizations. One NP participant made the point that, all things being equal, gender was probably the tipping point as to why NPs got 85% instead of 97%, and in other words, men would probably have fought harder not to accept that compromise (Pages 244-245).

Based on these matching patterns between the study findings and Bryson's feminist political theory, it is reasonable to accept that Bryson's theory is a suitable supportive explanation to help explain the midwife and nurse practitioner Medicare legislative process and outcome. It should be noted, however, that while the NP case

was selected to hold constant the variable of gender, there was one unanticipated aspect of gender that was different for the CNM case than the NP case. Nurse practitioners may be predominantly women, but the patients they care for are men, women, children and families. NPs were seen as one solution to a primary care shortage, something that all legislators could understand and support. Midwives, on the other hand, were women caring for women. Women's health care, and particularly maternity care, has not been an issue of great value for policymakers. So when midwives spoke about the *gender of the care recipients* and how *gender impacts political reception*, they did so with much more urgency and passion, because for them the political was doubly personal.

The Role of Economics and Special Interest Politics

In the first chapter of this dissertation I suggested that Feldstein's (2006) economic version of the interest group theory held particular relevance for midwives and nurse practitioners in their respective quests to garner economic reimbursement equity through the legislative process. The following chart summarizes the five central themes in Feldstein's economic version of the interest group theory, and then diagrams how patterns (themes) identified in the midwife and NP case interviews correspond with those major themes.

Table 7: Role of Feldstein's Economic Interest Group Theory in Medicare Reimbursement Efforts

Feldstein's Economic Interest Group Theory Themes	CNM and NP Shared Themes	Midwife Themes	Nurse Practitioner Themes
<i>Legislators make policy decisions based on the benefits they are likely to receive in political support</i>	Organizational resources	<ul style="list-style-type: none"> a. <i>small size of the organization</i> b. <i>amount of money for political advocacy</i> 	<ul style="list-style-type: none"> c. <i>size and appearances</i> d. <i>money and resources</i>
<i>Legislator benefits are weighed against the costs of time investment and political capital</i>		<ul style="list-style-type: none"> a. <i>importance of choosing the right sponsors</i> 	<ul style="list-style-type: none"> b. <i>political porters</i>
<i>Interest groups make decisions based on the perceived costs of organizing and providing political support</i>	<ul style="list-style-type: none"> a. <i>contributions of volunteer leadership</i> b. <i>engaging members and leadership in grassroots political advocacy</i> 	<ul style="list-style-type: none"> c. <i>amount of money for political advocacy</i> 	<ul style="list-style-type: none"> d. <i>money and resources</i>
<i>Interest groups weigh these costs against the potential benefits of a legislative solution</i>	Components of the Medicare bill	<ul style="list-style-type: none"> a. <i>Why 65% to begin with</i> b. <i>Why 65% didn't work</i> 	<ul style="list-style-type: none"> c. <i>Why direct payment was important</i>

The first theme of legislator benefits overlaps with the theme of ***organizational resources*** within the Organizational Capacity Category. In the midwife case *small size of the organization* did not lend itself to being a large vote incentive for policymakers. Neither was there a large *amount of money for political advocacy*. However, ACNM did recognize the importance of PAC dollars, and did work hard to support their sponsors with both contributions and political events (Pages 174-175). In the nurse practitioner case, *size and appearances* were sometimes deceiving. There were multiple organizations involved which sometimes made it look like there were more supporters of the bill, but most of the small NP groups did not have significant numbers of members that would have been a vote incentive. In contrast, ANA had a large membership, a well-organized grassroots lobbying effort, and a significant amount of *money and resources*. Most of the smaller organizations did not have a PAC at this time, but ANA had endorsed President Clinton, and was actively supporting members of the House and Senate with their million dollar PAC, so they were definitely the power player in this effort. (Page 233-235).

Feldstein's second theme of legislator time investment has some intersection with the subtheme of *importance of choosing the right sponsors* within the Politics and Political Process Category. One midwife case participant spoke about wondering if the House sponsor (Towns) was working the bill, and noted that he had not worked other bills he sponsored (Pages 169-170). Other midwife case participants spoke about the Senate sponsor (Conrad), and how his legislative

staffers were very helpful in keeping the midwife issue in front of him (Pages 152-153). In the NP case *political porters* subtheme, participants spoke about their Senate sponsor (Grassley) and how he and his legislative staff made passage of the bill a priority in their office (Page 214). They also spoke about the House sponsor (Towns) and how his staffer had gotten things moving on the House side (Page 209).

Feldstein's third theme, special interest group perceived cost of political advocacy, matched with a few of the midwife case and NP case subthemes under the Organizational Capacity and Political Competence categories. Midwife case participants spoke about dedicating resources, fundraising, and chapters supporting a policy intern in the *amount of money for political advocacy* subtheme (Page 175). In the *contributions of volunteer leadership* subtheme midwife case interviewees talked about hard working members of the PAC and GAC and passionate volunteers who put in hours of effort for the Medicare equity quest (Pages 177-178). In both the midwife and nurse practitioner cases the participants spoke about *engaging members and leadership in grassroots political advocacy*. CNM case participants related the efforts that went into building an aggressive grassroots campaign, and the organizational support for educating and motivating members and elected leadership to be effective advocates (Page 181). NP case participants spoke about individual NP efforts to educate and empower members (Page 239). In the NP case *money and resources* subtheme, participants spoke about the amount of resources ANA could dedicate to political advocacy, the lack of resources and money in the NP organizations, and of fundraising to afford a professional lobbyist (Pages 234-235).

In the *contributions of volunteers and leadership* subtheme, NP case participants talked about a small cadre of strong NP leaders that understood politics and helped to move the effort forward, and about the dedication and efforts of one passionate volunteer who dedicated a year to leading an aggressive grassroots effort (Pages 235-236).

The fourth theme of organizational potential benefits of a legislative solution overlapped with midwife and NP case subthemes in the Policy Agenda category. The ***Midwife Initial Inclusion in Medicare*** theme laid out *why 65% reimbursement happened to begin with*, and then *why 65% didn't work* because it was neither equitable nor sustainable for midwives (Pages 159-160). The ***Components of the Medicare equity bill*** theme discussed the different provisions that ACNM had included in the bill and worked for over the 19 year effort, and then addressed the equal pay for equal work argument that led to 100% reimbursement for midwives (Pages 161-163). In the NP case subtheme *why direct payment was important*, participants explained why incident to billing wasn't working, and how direct billing would confer autonomy and show federal recognition of the profession. In the *85% reimbursement* subtheme NP case participants spoke about how 85% was better than nothing and better than the 65% CNMs were getting. And in the *other reimbursement percentages* subtheme they lamented that 100% was not sellable but would have leveled the playing field, and spoke about the equal pay for equal work argument that was abandoned in the compromise for 85% (Pages 223-225).

Finally, Feldstein's fifth theme, organizational political competency, matched with several subthemes across the Organizational Capacity category. Under ***organizational leadership and management***, midwife case participants spoke about *national office issues* that impacted the progress of the effort, and differences in *lobbyist effectiveness* that helped or hindered the Medicare equity quest (Pages 176-177). NP case participants spoke about understanding the importance of having a *professional lobbyist* to represent them in DC (Page 235). Under ***individual and collective midwives / nurses and nurse practitioners*** both CNM and NP interviewees discussed *personal characteristics that impact political advocacy* competence (Pages 178-179, 236-237). Feldstein's organizational political competence theme also matched with all the themes and subthemes from the Political Competence category. Within the theme of ***Organizational Strengths*** all three shared subthemes highlighted areas that CNM and NP respondents saw examples of political competence: *persistence / persistent laser focus on the issue*, *engaging NPs / members and leadership in grassroots political advocacy*, and *evolving political sophistication* (Pages 180-182, 238-240). And within the theme of ***Organizational Weaknesses***, all five subthemes pointed to areas where political competence was compromised. Midwife and nurse practitioner case participants both thought that there had been *inconsistent and inadequate strategy development and inadequate coalition building*. CNM case participants believed that ACNM suffered from *poor messaging of decision, issues and accomplishments* and *not enough presence in DC*. And finally, NP case respondents cited *not enough collection*

or distribution of NP data as a detriment to NP political advocacy efforts (Pages 182-185, 240-241).

Based on these matching patterns between the study findings and Feldstein's economic version of the interest group theory, it is reasonable to conclude that Feldstein's theory offers a viable explanation for how and why the midwife Medicare equity quest and the nurse practitioner Medicare reimbursement effort unfolded as they did. Feldstein's theory additionally could be used to explain the differences in the process and outcome between the two groups' legislative efforts.

Summary

This chapter presented the comparative findings from the midwife and nurse practitioner cases. The historical narratives and thematic analyses were compared for similarities and differences between the two cases. Then findings from the individual and comparative cases were used to address the research questions, looking first to explain the process length of time and process outcome for each case. Finally pattern matching was used to compare the midwife and nurse practitioner cases with Bryson's feminist political theory and Feldstein's economic version of the special interest theory.

The final chapter will discuss the findings in this study. The chapter will include personal reflections about the midwife and nurse practitioner cases, limitations of the research, and implications for future research, education and policy.

CHAPTER 8: DISCUSSION

This final chapter discusses the findings of the midwife and nurse practitioner cases. It includes personal reflections about the two cases historically and observations from the research process with each case. It presents limitations of the study, and discusses implications for future research, policy and education.

Reflections

I began this dissertation stating that it had been my great privilege to have been a part of midwife struggle for Medicare equity: first as a member and officer in ACNM advocating for passage of the Medicare reimbursement legislation, and then as a congressional staffer working with colleagues to promote and pass the bill. In this section I will share my reflections from some of those experiences, as well as some thoughts about the NP and CNM processes and outcomes from the standpoint of someone who trained first as a nurse practitioner and then as a midwife, and who now has the opportunity to work on the front lines of policymaking.

Nurse Practitioner Case

I attended a generic master's degree nursing program at Pace University in 1976. During the two years I was there the administration decided to change its focus to a nurse practitioner program. None of the faculty at the time were NPs, so

along with teaching us basic nursing they were all in NP programs themselves and then trying to teach us some of the NP skills they were learning. After graduation we were all required to do an NP practicum, so I went to the Blackfeet Indian Reservation in Browning, Montana for three months to learn NP skills from a physician who was in the Indian Health Service. At the completion of that practicum I was issued an NP certificate, and felt utterly unprepared to be either a nurse or a nurse practitioner.

I share this background as a preface to saying that I never felt that being a nurse practitioner was a unique profession apart from nursing; it always just seemed like a different setting in which to practice as a nurse. We had been encouraged in school to join one of the nursing organizations, but never even introduced to the idea that there were NP organizations to join. Personally I felt very unconnected to my identity as a nurse practitioner, and two years later I went back to school at Columbia University to become a midwife.

The contrast couldn't have been more dramatic. From the very first day of midwifery school professional identity was taught and modeled. We were schooled in the history of the profession as well as its core competencies, and part of our eighteen month program was the requirement to attend that year's annual meeting. Every student was strongly encouraged to join the professional organization and to get involved in policy issues.

When I interviewed the ten participants in the nurse practitioner case, I was immediately transported back to my Pace University educational experience, and

after 35 years I finally began to understand how the nurse practitioner profession had been in its infancy when I had been in school. There were no professional organizations to join outside ANA except NAPNAP, and many of my classmates who went out and practiced as nurse practitioners were functioning under state nursing laws that did not even mention nurse practitioners, and with little collegial support from other NPs. Senator Inouye and Congressman Roybal had both introduced bills to give NPs direct reimbursement under Medicare by the time I graduated from my NP program, but I am pretty certain that not one of my faculties knew anything about that. And I suspect neither did most NPs working isolated in their communities around the country.

When I began to search for documentation of the early policy efforts of NPs I was frustrated to find that no one had kept those records. The AANP had formed in 1985, but there were no policy newsletters that had been saved. The Alliance that formed out of the Chicago Forum had dissolved after a few years, and there were no records left from that organization. The ACNP did not have access to the earliest newsletters from their organization after it was formed in 1993. In fact the only place that I was able to find written policy records about the NP Medicare reimbursement effort was through ANA. There were 17 years of policy efforts for direct Medicare reimbursement that had gone on before the introduction of the Grassley bill in 1991, and six years until the passage of that Grassley bill, but it is my sense that documentation of those 23 year efforts outside of ANA exists now only in the memories of a few NPs who were involved in them.

The most dramatic realization that I had during the NP interviews was the lack of communication between most NP groups and nursing during the Medicare reimbursement effort. I interviewed nine participants from different NP groups and they all spoke about the effort as it had been directed and supported primarily by one or more NP groups. Then I interviewed a policy staffer who had been at ANA during the Medicare endeavor, and it became immediately clear that ANA had been the power player in that effort, and they had the records to prove it.

Midwife Case

My first recollection of the midwife Medicare equity effort was while I was on the Board of Directors, and the first solo midwife bill was introduced. I remember that as a BOD member we were expected to be engaged in advocacy, so on a few occasions I went to the Hill to lobby for cosponsors. My Congressman was a Republican, and I recall the complete disinterest of the staff in his office when I tried to speak about midwifery and Medicare payment. I visited other offices with other BOD members, and remember thinking that no one in Congress was interested in whether midwives were paid equitably for their services.

During the time I was on the Board (1996 – 2000) and the years following that when I chaired the Division of Women’s Health Policy and Leadership (2000 – 2005) I was frequently involved in policy discussions and meetings at the College. I remember thinking that this Medicare effort was one of many issues that ACNM was involved with. There didn’t seem to be any organized approach to creating a policy

agenda or to developing strategy to move the bill. The first lobbyist was let go towards the end of my tenure with the Division, and I recall thinking that maybe there would be a change in how policy was approached with the new contract lobbyist.

I won a Congressional fellowship in 2005 and went to work in the office of Congresswoman Lucille Roybal-Allard. During my first year on the Hill I remember wondering what was going on with the bill and why the sponsor was not sending out any Dear Colleagues to promote cosponsorship. ACNM had its annual meeting in DC that May so there was a lot of activity around that, and hundreds of midwives came to the Hill to lobby. But after I took a job in the Roybal-Allard office in September of 2005, for the next year and a half there didn't seem to be much visibility for midwives or the Medicare bill on the House side. Of course, the staffer in Towns office had passed away in 2005, and after that there were a stream of health legislative assistants in the office. But I made it a point to introduce myself to each one of them, and always found it frustrating when they told me that I was the only midwife they had ever met.

In the fall of 2006 my boss passed a stand-alone authorization bill to address underage drinking. The effort consumed our office for several months, but we were able to bring together all of the alcohol industry (who had not sat at a table together in memorable history) with the advocacy community (who were staunch adversaries of the alcohol industry) and get them to come to agreement on bill language. That enabled us to garner enough bipartisan support to pass a bill in a

Republican Congress. It was an amazing experience that left me thinking it was very possible for Members of Congress to pass seemingly difficult bills if they put enough heart and energy into the effort.

When the House was considering SCHIP reauthorization and developing the CHAMP Act I remember that my boss and Congresswoman Capps offered their help to Congressman Towns to try and get the midwife bill included in that omnibus legislation. As it turned out it was included, and passed the House, but never made it through the Senate side. But the whole year I kept thinking that if Mr. Towns had wanted it more he might have been able to levy some support in the Senate for getting it included in their Medicare omnibus bill.

Two years later President Obama came to the White House and health reform dominated the political agenda for the next year. Health reform is an all-consuming effort in Congress. The political hype by Republicans was that the *Affordable Care Act* (or Obamacare as it is known in many circles) was rushed through and nobody knew what was in it. This couldn't be farther from the truth. Every health staffer in every House and Senate office spent an entire year working on this effort. Health Reform raises the individual and collective health consciousness and knowledge level by light years over a normal Congressional year.

In 2010 I sat in the balcony of the House of Representatives as the final vote to pass the Affordable Care Act was going on. Besides the incredible opportunity to be there for such a historic moment in political history, I also remember thinking that I was witnessing the end of a 19 year effort by ACNM. It felt to me like it had

been a mismanaged policy effort on the part of both ACNM and the Congressional offices, and that there had been multiple opportunities where the bill could have passed. I realized then that I wanted to gain a deeper understanding of why this legislative endeavor had taken so long.

It was an enlightening journey to do this research. I started with the interviews of the 14 midwife case participants, and their stories reaffirmed some of my own memories and filled in gaps where I had no recollections. I was concerned at first because some of their remembrances were weak when it came to dates and decisions, and a few times seemed to contradict each other. But then I moved on to reviewing the documents at the ACNM office, and that clarified any questions that had arisen. The review of Congressional documents was tremendously informative, and then repeating the entire process with the NP case added another dimension by which to understand the 19 year effort. Together, the findings from the two case studies gave me a much deeper understanding of the multiple forces involved in passing legislation.

Discussion

In 1991 two groups of seemingly similar advanced practice nurses worked with Congressional offices to introduce a 97% Medicare reimbursement bill. Six years later the nurse practitioners achieved direct Medicare reimbursement at 85% of the physician fee schedule. It took another thirteen years, or nineteen years from the original bill introduction, before resolution of the midwife Medicare payment at 100% of the physician fee. The purpose of this study has been to formulate an in

depth understanding of the politics, personalities and processes that defined the midwife Medicare reimbursement effort, and to explore how and why the process differed from the nurse practitioner Medicare reimbursement effort. These are the things I have learned from this study.

First, it is important to have adequate frameworks by which to evaluate a policy effort. Longest (2010) describes a health policy making model in which social problems come together with legislative solutions in particular political circumstances to open a window of opportunity that allows legislation to become law. Longest's model works well to explain why a particular piece of legislation passes at a particular point in history. But it is a stretch to explain a 19-year policy effort with a singular model.

Wong (1999) also used a single model when she explored the NP Medicare reimbursement quest in the only previous study to evaluate that policy effort. She found that Kingdon's framework was sufficient to explain the success of the nurse practitioner reimbursement effort during the 105th Congress. Wong observed that political pressure to get Medicare costs under control resulted in a vehicle (the Balanced Budget Act of 1997) that carried the NP legislation, and that effective lobbying by multiple nursing organizations added to the success of the effort. She did not take into account the entire 23 year history of the nurse practitioner effort for Medicare reimbursement, nor did she note the role that the ANA played in the successful resolution. Wong's study also neglected to address the role that gender played in the process and outcome, and only scratched the surface of evaluating the

competing costs and benefits to legislators and special interests. Some of Wong's shortcomings may be due research design, but it is more likely that Kingdon (and Longest's health adaptation of Kingdon) are valid models for looking generally at policy efforts, but they are not comprehensive enough to facilitate in-depth evaluations of multi-year policy efforts.

Second, legislation does not occur in a vacuum. In order to explain the course and outcome of a particular policy effort it is critical to understand the history around the legislative endeavor and the political climate over the years in which that effort was taking place. Medicare and Medicaid were programs established by Democrats and have always been under scrutiny and attack by Republicans. Policy change involving these two entitlement programs almost universally involves some sort of omnibus legislation rather than a stand-alone bill. Republican Congresses are more likely to pass Medicare changes aimed at cost-containment, and Democrat Congresses have a stronger history of passing expansions of eligibility and benefit expansions. The CNM/NP Medicare payment legislation was considered an expansion of benefits, and even with a Democrat Congress it necessitated some strong political impetus to move forward.

The political impetus in the 1990s was a growing shortage of primary care providers. Physicians were largely choosing specialty practice and payment mechanisms that favored medical specialties, so APRNs were increasingly being looked to as a resource to fill in the national need for primary care providers. By the 2000s this was complicated further by large numbers of uninsured and

underinsured, and unresolved numbers of primary providers to meet their needs. Two Democrat Presidents undertook health reform efforts to address the critical problems in the health care system. Those health reform efforts altered the political landscape by raising the health care IQ of virtually every legislator and health staffer in Congress. The NP bill passed shortly after the first failed health reform effort and the midwife bill passed as a part of the second health reform effort. Timing and the presence of a vehicle were critical in both of the efforts, but the differences in outcomes between the two groups necessitates an understanding of one further piece of history.

When Senator Grassley introduced the first 97% Medicare reimbursement bill for midwives and nurse practitioners it appeared to be a similar effort. In truth, CNMs and NPs were not starting at the same place. Nurse practitioners had been trying since 1974 to attain direct reimbursement under Medicare. Midwives had been getting direct Medicare payment since 1988, albeit at a level of reimbursement that was lower than they felt they deserved. Nurse practitioners and midwives formed a coalition in 1991 to achieve a common goal, but their motivations were uniquely different, and the way they were perceived by policymakers was also very different.

The third finding of this study is that Feldstein's economic version of the special interest group theory provides that stronger lens necessary to evaluate a multi-year policy effort, and is an adequate explanation for the different processes and outcomes in the two cases. According to Feldstein, suppliers of legislative

benefits are always motivated to some degree by the need to be reelected and make decisions based on the benefits they are likely to receive in political support in votes and money weighed against the costs in the amount of time they will need to invest in the legislative activity. Organized interest groups also make decisions based on the perceived costs of organizing and providing political support versus the potential benefits of a legislative solution. The success of these groups takes into account their political competency in convincing policymakers their issue is a worthwhile investment of political capital (Feldstein, 2006).

The nurse practitioner bill passed in six years but at a reimbursement rate that was a compromise from the original bill request. From the supplier side, legislators who supported the NP bill had not only the support of NPs but also nurses, who at the time were a major power player with a million dollar PAC. No doubt they experienced push back from physicians, but the administration was strongly supportive of giving NPs direct Medicare reimbursement and it could be messaged as an effort to improve access to health care which made them appear to have the public interest at heart. On the interest group side, NPs needed direct reimbursement; it was critical to their survival. They could afford to compromise for 85% but they could not afford to continue without the ability to bill directly for their services. As to costs, there were multiple groups of NPs to share the costs of advocacy, and again ANA had a vast amount of resources they could invest. And as far as political competency was concerned, NPs may have been weak on strategy,

data dissemination and coalition building, but ANA had experience and connections and with a well-oiled grassroots machine.

Midwives waited nineteen years to resolve their Medicare equity bill, but they ended up with 100% reimbursement. From the supplier side, legislators who championed the bill for so many years had the loyalty and support of the midwives, but there was not a lot of money and votes that went along with that. On the other hand, for many of the years of the bill there was not a lot of investment on their part to moving the bill. The interest group side was also quite different from the nurse practitioner effort. For midwives, Medicare reimbursement was not directly critical to their survival; it was only when they began to view it as setting the standard for other third party payers that there became a strong philosophical urgency for resolution. The costs were high for a small organization, and the resources invested over the years that it was the top legislative priority were enormous. At some point the cumulative investment became such that it critically needed to be resolved. As for competency, CNMs had the same problems as NPs with inconsistent strategy and inadequate coalition building, along with not enough presence in DC. Their persistence and evolving political sophistication improved the efforts over the years. But the major difference was that until the final push to include their bill in health reform, midwives did not have the backup of ANA's political resources and power. They had to rely on passionate volunteers engaging the rest of the membership in grassroots advocacy.

The fourth factor is the role that feminist political theory played in the processes and outcomes of the midwife and nurse practitioner cases. I began this dissertation with the assumption that by choosing the NP Medicare reimbursement effort as a second case, I was holding constant the variable of gender. Both midwives and nurse practitioners were predominantly women practicing what has traditionally been seen as a woman's profession. Both groups found that to some degree gender impacted their political capabilities, and both groups experienced varying degrees of gender impacting the way they were received and perceived by policymakers. What I had not realized, and what I now believe to be a critical piece of understanding these two cases, was that gender impacted midwives in a third and most powerful way.

Midwives are not only women practicing a traditionally women's profession, but their care recipients are also women. This is where the midwives and nurse practitioners diverge in their similarities. NPs are women practicing a traditionally women's profession, but the people they care for are children, adults and families. There was a perceived need in the 1990s for more primary care providers for children and adults, but there was no perceived shortage of obstetrical care during that same time.

By the 1990s there had been significant research showing that midwives provided the same or higher quality care for a lower cost than traditional ObGyns (Brown & Grimes, 1993; Office of Technology Assessment, 1986; Rooks, 1997). But the political conversation in the 1990's was not centered on the cost or quality of

maternity care. The *Women's Health Equity Act of 1989* had focused federal attention on eliminating disparities in women's health services, research and prevention, but most of the attention was disease specific (Jessup, 2007). Health reform under President Obama changed the conversation around cost and quality of all health care, including women's reproductive health care. It provided the climate and the vehicle to resolve the midwife Medicare equity request.

One last point needs to be considered about the role of gender, and the timing of the Obama administration during the 111th Congress. The first legislation passed by the new Democrat majority in the 111th Congress and signed into law by President Obama was the *Lilly Ledbetter Fair Pay Act of 2009*. It was a dramatic public statement that this administration and this Congress believed women deserved to be paid fairly and equally for their work when it was the same as a man's work. Midwives had been making that argument for years about why they should be reimbursed 100% of the physician fee schedule under Medicare. In addition to the many other factors that played a role over the years in the midwife Medicare equity effort, the Obama administration and the 111th Congress was the perfect storm to resolve the nineteen year quest of midwives to achieve equal pay for equal work.

Limitations

There were two major limitations in this study. The first was in the depth and breadth of data collected in the nurse practitioner case. Because the NP groups had been in their infancy during the Medicare reimbursement effort there wasn't a lot of

attention paid to records preservation. The Alliance had records at one point, but one of the interviewees reported that she used to have boxes of records in her basement that she had finally disposed of during her last move. AANP had sent out a policy newsletter for years, but those documents were not stored at the Texas headquarters. The AANP interviewee told me that she had kept those newsletters for a long time, but didn't know where they were any more. The first few years of the ACNP newsletter were not available even through the current publisher. Additionally, there were several more individuals who had played a big role in the Medicare saga, but I was unable to track them down and then time became too short to keep trying. The NP case would have been richer had I had access to the documents and additional interviews.

The second limitation also involved time and availability constraints. The original proposal called for a set of interviews involving current and former congressional staff that had been involved with the nurse practitioner and/or midwife cases. Three names came up repeatedly in the NP interviews. One of those staffers had passed away in 2005 and one had moved to France and no one knew how to find him. The third former congressional staffer is currently in a position of authority within the government. She was contacted but declined to participate in the study, because she said she couldn't remember enough to be valuable. The process of identifying other current and past congressional staff was cut short by university time constraints, and the decision was then made with my committee to forego congressional staff interviews. It was an unfortunate but unalterable

decision, and the dissertation is therefore missing that unique dimension of insight from the point of view of those who had been working in the policy arena when the nurse practitioner and midwife legislations were being considered.

Implications

There are a number of implications and recommendations that stem from this research. They fall into four main categories: implications for future research, implications for policy at the federal congressional level, implications for policy efforts of the two organizations, and implications for education.

Research Implications

There are a number of research implications that arose during the course of completing this dissertation. The first and most obvious would be the originally intended section of this study from the point of view of congressional staff looking at the NP and CNM Medicare policy efforts. Congressional staff insight into midwifery issues in general, or nurse practitioner policy efforts, would also make a valuable research study.

The question came up during the course of this research as to what had transpired with the nurse anesthetist Medicare reimbursement efforts. CRNAs would have made an obvious choice if a third case had been included in this study, and it would be interesting to replicate this study with the nurse anesthetists and then include them in a comparative case analysis with the midwife and nurse practitioner cases.

In the course of doing the literature review for this dissertation it became apparent that while there are volumes written on Medicare history, including all the efforts to rein in costs and all the attempts to expand the program, there is a paucity of information on the role non-physician providers have played in Medicare. The program expansion literature always speaks about services and treatments that were added, but little is written about how and when each group of non-physician providers achieved direct reimbursement, and what have been and continues to be their limitations and challenges. That perhaps could be the subject of a post-doctoral research endeavor.

Finally, and probably most the most significant research implication of this dissertation, is the use of the case study as a research methodology. I chose to use a method that has not traditionally been employed in nursing research, despite the fact that it is a respected and valuable method across the social sciences of sociology, psychology and political science. In fact, the case study as a method was not taught or even mentioned in either of my basic or advanced qualitative methodology classes. For that reason I devoted an entire chapter of this dissertation to discussing the history, description and rigor of case study research.

The case study method allowed me to explore multiple facets of the political process as it was experienced by two nursing special interest groups and afforded the most comprehensive picture of how and why the two processes and outcomes were different for the two groups. For this dissertation I believe it was the very best choice of methodologies possible. I therefore believe that nursing research would be

greatly enriched by expanding the use of the case study method. It is an ideal approach for looking at nursing policy efforts, but it would also be a valuable methodology for assessing nursing interventions. For example, the following chart suggests different case study designs for the research question: How do hospital nurses address hospital acquired infections?

<p>Single Case Holistic Design:</p> <p>Looks at a single hospital as the operational unit of analysis to determine how HIA's are addressed</p>	<p>Multiple Case Holistic Design:</p> <p>Compares the HIA operational plans of one hospital to other hospitals in the same community.</p>
<p>Single Case Embedded Design:</p> <p>Looks at specific nursing care units within a specific hospital in order to determine how the hospital as a whole was handling the challenge.</p>	<p>Multiple Case Embedded Design:</p> <p>Looks at how the specific nursing units within each of the hospitals to compare how different hospitals were operationalizing their HIA plans.</p>

Figure 14: Case Study Design Examples for HIA Management Research Question

Congressional Policy Implications

I set out on this journey to understand why midwives and nurse practitioners efforts to attain equitable Medicare reimbursement took such different paths. In the process I discovered a political legacy that has implications for future legislative efforts.

I work for a Member of Congress who will have been in the House of Representatives for 20 years this January. She followed in the footsteps of her father, Edward Roybal, a much loved politician who served in the House of Representatives from 1963 to 1993. We know a lot about the political legacy of this great public health advocate; his leadership in senior health and economic security, and his groundbreaking efforts to address the HIV/AIDS crisis. What we did not know was his long history of championing Medicare, Medicaid and FEHBP payment for nurse practitioners and nurse-midwives, and the fact that it was his Treasury Appropriations bill that gave them direct FEHBP payment in 1990.

The bill that Congressman Roybal first introduced in 1977 to provide mandatory reimbursement under Medicare and Medicaid for nurse practitioners has changed over the years. It was picked up by his Congressional Hispanic Caucus colleague, Congressman Richardson in 1992 as a bill to provide mandatory reimbursement under Medicaid for nurse practitioners and clinical nurse specialists. In 1997 that bill was picked up by another Hispanic Caucus member, John Olver, when Richardson was retiring. Under Congressman Olver the bill changed and became the *Medicaid Advanced Practice Nurses and Physician Assistants Access Act*, to provide mandatory reimbursement under Medicaid and specify that NPs, CNMs and PAs can serve as primary care case managers. Congressman Olver is retiring this year, and because of the history uncovered through this dissertation, Congressman Roybal's daughter will become the sponsor of this Medicaid bill in the 113th Congress.

Organizational Policy Implications

For both midwives and nurse practitioners there was tremendous growth in individual and collective political competency over the course of their Medicare policy efforts. However, there were weaknesses identified for the two groups that I believe have present day implications for policy advocacy. One of these is for midwives, one for nurse practitioners, and one is a collective recommendation for the two groups.

During the interviews participants in both cases pointed to the fact that ACNM does not have enough presence in DC. At most they hold their annual meeting in DC every four years. Every time there has been a strong DC presence midwives saw great progress in the number of new Medicare bill cosponsors. Currently midwives have two legislative efforts they are championing, but there has been no DC meeting since the passage of the Medicare equity bill in 2010. Other professional organizations hold annual meetings in DC, or sponsor member fly-in days for advocacy on the Hill. Certainly from a congressional staffer viewpoint, I can attest to the fact that even the most outstanding lobbyist is no substitute for meeting with professionals who come to share their compelling stories. And the comments that I shared from staff in one of the House champion offices, that I was the only midwife they had ever met, are very concerning revelations. The College has made several attempts to address this, including having the BOD spend one day during each of their quarterly meetings making Hill visits, and organizing an advocacy month each August during which members are encouraged to meet with their legislators in their

districts. I commend them for those efforts, but I also believe that there are further steps that are critical to the organization's political future.

ACNM needs to make a commitment to a stronger DC presence, and I would echo the statements from one of the midwife case participants that once every four years is not often enough for meetings in DC. This could be accomplished by holding annual meetings in DC at least once per Congress (every two years), or by holding annual educational meetings in DC that also include a lobby day. Perhaps there could be a financial incentive for members to attend these and spend a day on the Hill educating members and promoting the midwifery model. Maybe the College should consider doing something like this in conjunction with other midwives and midwifery consumers. Imagine the power of a "midwifery, moms and apple pie day" every year near Mother's Day, where midwives and midwifery consumers would storm the Hill to tell Congress we can do better for our moms and babies, and the midwifery paradigm is the way to do that!

Another less ambitious, but also very powerful, statement of presence would be to sponsor a yearly congressional fellowship for one or two midwives. The day to day presence of a midwife working with congressional staff in other offices helps to build relationships and to educate by association about some of the issues that midwives care about. Over time it would also build a cadre of very knowledgeable political advocates for the College.

The second weakness I will address concerns the nurse practitioners. During the interviews with nurse practitioners, participants discussed inadequate data

collection and distribution. They believed that midwives had always done a better job of focused outcome research and dissemination of that data. Nurse practitioners were faulted for their predilection for consumer satisfaction surveys rather than cost effectiveness research. In the years since the passage of the 85% Medicare reimbursement, NP numbers have exploded, and NPs have certainly grown in their visibility and acceptance by policymakers. However, during all those years nurse practitioners have neither been able to pass the long-standing Medicaid bill or a Medicare home health bill. So obviously there is still work to be done.

Nurse practitioners have suffered over the years by multiple organizational representations and by not having one strong and collective voice. The announcement made in July that the AANP and ACNP will be merging organizations is an opportunity for nurse practitioners to speak in one voice, recommit to the development of strong cost-effectiveness research, and foster a policy agenda that speaks for all nurse practitioners in the country.

The last weakness I will address was shared by both groups, and to some degree is still a problem today. Participants in both cases spoke about inadequate coalition building. This included working with organized nursing, collaboration among all APRN groups, and forming coalitions with consumers. During the 111th Congress health reform deliberations nursing coalesced in an unprecedented effort to put forth a common agenda. Hopefully this ability to come together will continue in the future. But there are definitely times when nurse practitioners and midwives have unique or common interests that are separate from the nursing agenda. The

ability to form diverse political coalitions around differing agendas is critical to moving midwife and nurse practitioner issues forward. Both groups need consider expanding their coalitions to include health advocacy organizations and consumer groups. Additionally, nurse practitioners and midwives would be wise to learn from the examples of direct entry midwives who have successfully harnessed the power of their consumers in order to impact state policy. I believe that the untapped resource of loyal and satisfied midwife and nurse practitioner patients has the potential to impact policy and begin to alter the paradigm of physician directed and disease oriented health care in this country.

Educational Policy Implications

I began this section by discussing the research implications of expanding utilization of the case study methodology. It has been my observation over the many years that I have been associated with George Mason University (GMU) nursing that qualitative methodologies have taken more and more of a back seat to the traditional quantitative research methods. The few faculties that still engage in qualitative research almost universally use Phenomenology as their method, and as I mentioned earlier, the case study as a method was not taught or even mentioned in either of my basic or advanced qualitative methodology classes. Therefore it is my strong recommendation that the GMU School of Nursing (and of course other universities that offer graduate nursing programs) incorporates the teaching of case

study methodologies into all graduate research courses, in order to expand and enrich the potential research of future students.

In the first chapter of this dissertation I suggested that despite progress in the political advocacy of midwives and nurse practitioners over the last two decades, most advanced practice nurses today still view the political process as vague and unsettling. The insights gained during the case study will add to ACNM and NP professional organizations' political knowledge base of the legislative and political processes. It is my hope that this information will subsequently be used to develop teaching models that will increase political competency of midwives and nurse practitioners.

Both nurse practitioners and midwives have continuing competency requirements in order to maintain certification and licensure. Rightfully most of these offerings focus on maintaining clinical competence. But consider the potential for increasing political competence if every practitioner was required to complete a policy module in order to satisfy proficiency requirements. Imagine the political implications if there was a way to build in an advocacy experience at the local, state or federal level as part of certification renewal program.

It is a dream, of course, but it could easily be a reality at the basic educational level. Every nurse practitioner and midwifery program should include a strong policy component. Just as there was a difference in my nurse practitioner and midwifery educational programs in how they promoted a professional identity, I believe every program has the potential to instill a responsibility to be politically

active. Students should be taught about the political process and then taken by the hand and walked through an experience of advocacy. Part of molding the nurse practitioner and midwife professional identity should be an expectation that each practitioner would continue their political involvement throughout their careers.

Dissemination of Findings

I believe that the findings of this study will be of critical interest to midwives, and of strong interest to multiple groups of nurse practitioners in this country. Because the case study presents an analysis of a health policy process that played out over 19 years and 10 congresses, it may also hold significant interest for the wider health policy community. Therefore it is my intention to share the content and findings from this study in a varied number of venues.

The comparative case study will potentially generate a number of papers to be submitted to peer-reviewed journals directed at midwives and nurse practitioners. Specifically these journals may include: the *Journal of Midwifery and Women's Health*, the *Journal of the American Academy of Nurse Practitioners*, the *Journal for Nurse Practitioners*, the *Journal of Pediatric Health Care*, and the *Journal of Gerontological Nursing*. Additionally I may explore health policy venues for publication that will include: *Health Affairs*, *Health Policy and Planning*, the *Journal of Health Politics, Policy and Law*, and *Politics, Policy and Nursing Practice*.

I will also submit applications to present the findings at professional conferences directed towards nurses, midwives, nurse practitioners, and health

policy groups. Eventually the research will be developed into a case study teaching tool for policy classes in nursing and health services.

Albert Einstein once said “Learning is experience. Everything else is just information.” It is my hope that this dissertation will be more than just information; rather it will help midwives and nurse practitioners to learn from their experiences to become more effective policy advocates.

APPENDIX A

HSRB Informed Consent Form

MIDWIVES, NURSE PRACTITIONERS AND MEDICARE: CASE STUDY COMPARATIVE ANALYSES OF MEDICARE REIMBURSEMENT EFFORTS INFORMED CONSENT FORM

RESEARCH PROCEDURES

This research is being conducted to gain an in depth understanding of Midwife Medicare reimbursement political process, and to explore how and why that effort differed from the NP Medicare reimbursement process. If you agree to participate, you will be asked to take part in a 30 minute interview about the legislative efforts of midwives / nurse practitioners to achieve equitable Medicare reimbursement.

RISKS

The only foreseeable risks to participants in the study would be for currently employed Congressional staff or Committee Staff, if your employer perceived that you were sharing inappropriate reflections about fellow employees or Members of Congress. If you agree to participate in the study you may choose a pseudonym for the interview. Additionally, the transcript from the interview will be shared with you and you will have the chance to remove any comments that you are concerned might be perceived as inappropriate.

BENEFITS

There are no benefits to you as a participant other than to further understanding of the political efforts of two advanced practice nursing professions. The final research product will add to the nursing professional organizations' overall knowledge of the legislative and political processes, and can subsequently be used to develop teaching models that will increase political competency of NPs and CNMs/CMs.

CONFIDENTIALITY

The data gathered in this study involves interviews and therefore it will **not** be possible for you to remain anonymous. However, every effort will be made to safeguard your responses and maintain confidentiality by ensuring that your identity is known only to the researcher. Anonymity in reporting will mean that you are only identified by a classification (such as past ACNM president, NP government affairs committee member, or congressional office staffer). An alternative would be for you to choose a pseudonym for use in the reporting of this research.

PARTICIPATION

Your participation is voluntary, and you may withdraw from the study at any time and for any reason. If you decide not to participate or if you withdraw from the study, there is no penalty to you. There are no costs to you or any other party

AUDIO TAPING

All interviews for this study will be audio taped, and the tapes will be transcribed verbatim by either the researcher or a professional transcriptionist. No one else will have access to the tapes. Within one month of the interview the transcript will be returned to you for your review and approval before any of the information is used in the study. The original audiotapes will be kept secure in the researcher’s home office until completion of the doctoral research, and then they will be destroyed.

CONTACT

This research is being conducted by Debbie Jessup, a doctoral student in the School of Nursing at George Mason University. She may be reached at (703) 599-1136, or by email at debbie.jessup@mail.house.gov for questions or to report a research-related problem.

The chair of this doctoral research is Dr. Vanora Hundley. She may be reached at (703) 993-1933, or by email at vhundley@gmu.edu. You may also contact the George Mason University Office of Research Subject Protections at 703-993-4121 if you have questions or comments regarding your rights as a participant in the research.

This research has been reviewed according to George Mason University procedures governing your participation in this research.

CONSENT

_____ I have read this form and agree to participate in this study

_____ I agree to audio taping.

_____ I do not agree to audio taping.

_____ I wish to remain anonymous in the reporting of this research.

Name

Date of Signature

APPENDIX B

Case Study Protocol

A. Outline of the Case Study Project

1. Purpose of this Study
 - a. To formulate an in depth understanding of the politics, personalities and processes that defined the CNM/CM Medicare reimbursement efforts
 - b. To explore how and why the process differed from the NP Medicare reimbursement effort.
2. Study Questions
 - a. Why did the NP and CNM/CM organizations fare so differently in their efforts to achieve payment equity? Specifically the study will attempt to address:
 - i. Why did the process take 5 years for NPs but 18 years for the CNMs/CMs?
 - ii. Why were the NPs successful in achieving only 85% reimbursement while the CNM/CM legislative endeavor resulted in 100% reimbursement?
 - b. How did feminist political epistemologies shape the actions and decisions of the players in this political process?
 - c. How were the efforts of CNMs/CMs and NPs to achieve equitable Medicare reimbursement impacted by special interest politics?
3. Theoretical Framework and Process Model
 - a. Feminist Political Theory (Bryson, 1992)
 - b. Feldstein's (2001) economic version of the interest group theory
 - c. Longest (2010) Model of Public Policy Making in the United States
4. Role of the Protocol
 - a. To clarify and guide field procedures
 - b. To standardize field procedures across cases
5. Creation of Audit Log
 - a. To track decisions about development of the proposal and protocol
 - b. To track decisions about data sources and sampling choices within the cases
 - c. To track decisions about selection of analytic techniques

B. Field Procedures

1. Access to case study sites
 - a. Researcher works on the Hill, therefore has access to other member office staff and committee staff
 - b. Researcher is a member and past BOD member of ACNM and has support of the organization for this research, therefore will have access to all relevant documents and CNM/CM members and staff who have been involved in this legislative effort
 - c. Researcher has approached past faculty mentor who wrote the NP reimbursement legislation and she has agreed to facilitate access to NP organizations (AANP and ACNP) and relevant members and staff
2. Human Subjects Protection
 - a. Researcher will be making application to GMU Human Subjects Review Board upon approval of study proposal.
 - b. Sample informed consent form attached (see Appendix F)
3. Sources of Data
 - a. ACNM documents pertaining to legislative efforts such as minutes of BOD meetings and reports submitted by staff and volunteer government affairs leaders
 - b. NP organizational documents pertaining to legislative efforts such as minutes of BOD meetings and reports submitted by staff and volunteer government affairs leaders
 - c. Interviews with ACNM Presidents, Executive Directors, Directors of Professional Affairs, GAC and PAC volunteer leaders, and lobbyists who were involved during the 19 year legislative effort. Will sample within this group until saturation is reached.
 - d. Interviews with NP leaders and government affairs volunteers who were involved during the 6 year legislative effort. Will sample within this group until saturation is reached.
 - e. Congressional office staff and records as available

C. Case Study Questions

1. Professional Organizations
 - a. What do you remember about the Medicare reimbursement efforts of your organization?
 - b. What do you think was responsible for the non-passage of the legislation the years it saw no activity?
 - c. What do you think was responsible for the passage of the bill the year it was acted upon?
 - d. Do you recall any personalities, events or decisions that had either a positive or negative impact on the course of the legislation?
 - e. What do you think your organization did well in promoting this legislation?

- f. What do you think your organization could have done better to promote this legislation?
 - g. Was your professional organization strategizing in a proactive effort on this legislation, or were you engaging in the process in a more reactive way?
 - h. What role do you think the size and resources of your organization had on the process and outcome?
 - i. What role do you think gender had on the process and outcome?
2. Congressional offices and committees
- a. What do you remember about the Medicare reimbursement efforts of Nurse Practitioners/Midwives?
 - b. What do you think was responsible for the non-passage of the NP (CNM) bill the years it saw no activity?
 - c. What do you think was responsible for the passage of the NP (CNM) bill the year that it was acted upon?
 - d. Do you recall any personalities, events or decisions that had either a positive or negative impact on the course of the legislation?
 - e. Who do you remember as the primary stakeholders in the NP and CNM efforts?
 - f. What do you think professional organizations could have done differently to have altered the course of the NP (CNM) legislation?
 - g. Is there anything your office could have done differently to alter the course of the NP (CNM) legislation?
 - h. What role do you think the size and resources of the organizations had on the process and outcome?
 - i. What role do you think gender had on the process and outcome?

D. Case Study Report

- 1. Chronological narrative of NP Medicare reimbursement effort
- 2. Chronological narrative of CNM Medicare reimbursement effort
- 3. Evaluation of NP Medicare reimbursement effort
- 4. Evaluation of CNM Medicare reimbursement effort
- 5. Cross case comparison of NP and CNM reimbursement effort

APPENDIX C

Example of Narrative Summary

NP01 NARRATIVE

NP01 was interviewed on March 23, 2012. Her relationship with the NP case was as a women's health nurse practitioner and active member of her state nurses association.

Historical Reflections:

NP01 remembers that nurse practitioners were not receiving direct reimbursement under Medicare, and while this did not impact her practice, she believed it would be good for nursing and other NPs if they could be paid directly for seeing Medicare patients.

NP01 recalls a lot of controversy over the decision to go for 85%. She remembers a lot of NPs who wanted to go for 100%, but others who were willing to take 85% to get their foot in the door. She also remembers discussion about whether or not the clinical nurse specialists should be included in the effort.

NP01 describes multiple organizations trying to represent NPs. There was an effort to bring these groups together in a coalition, and that did not work well but ended up evolving into the ACNP.

According to NP01 getting the 85% didn't have the impact that NPs had hoped. Many practiced that employed NPs continued to bill under the sponsoring physician's name in order to get 100% payment for the practice.

Factors Influencing Process and Passage:

NP01 states that NPs were so much fewer in number when this effort was going on, and they were not really visible to members of Congress. This was before the IOM report, nobody knew who they were or what they did, and they were seen as a kinky sort of fringe group of nurses. But direct Medicare reimbursement was important because Medicare was becoming the gold standard for other payers.

NP01 recalls that policymakers did not fully understand that NPs were already seeing patients and using incident to billing, and therefore they were afraid that giving them direct payment under Medicare was going to raise the costs substantially. She believes there was a pervasive belief among the organizations that to counteract this fear NPs needed to be seen as the discount providers.

NP01 remembers that physicians were very much in opposition to any expansion in autonomy or payment for NPs. She believes that has not changed over the years. NP01 states that in the early years of the profession most NPs were young and female. They were busy starting practices and raising families, and did not have time to get involved in advocacy. She also believes that nursing attracts a personality type that wants to be helpful and doesn't want to rock the boat.

Organizational Strengths and Weaknesses:

NP01 believes that the disorganization of nursing and nurse practitioners played a role in the six year process. There were too many nursing and NP organizations and it was very difficult for them to present a united front. She also feels that NPs should have demanded that ANA represent them better, rather than starting new organizations to fix the problem.

NP01 thinks that NPs did a good job of educating members of Congress about the profession. She believes, however, that it is still a problem for NPs that they have not invested in research that can document the cost effectiveness of their practice. They have been too focused on research that shows patient satisfaction rather than outcomes and costs.

Finally, NP01 believes that nurse practitioners will never be equal providers until they learn how to take the power into their own hands. They could do this better if they would unite and speak in one voice like the nurse anesthetists do.

APPENDIX D

Midwife Medicare Equity Documents & Timeline

Year	Congress (H / S)	President	Quickening/Advocates	ACNM Minutes / Internal Documents	Testimonies / Publications	Congressional Bill Summaries / Federal Publications
1965	89 (D / D)	Johnson (D)				HR1/S1 Social Security Amendments of 1965 – become Public Law 89-97 in July 1965, Medicare and Medicaid are established
1966	89 (D / D)	Johnson (D)				
1967	90 (D / D)	Johnson (D)				
1968	90 (D / D)	Johnson (D)				

1969	91 (D / D)	Nixon (R)				
1970	91 (D / D)	Nixon (R)				
1971	92 (D / D)	Nixon (R)				
1972	92 (D / D)	Nixon (R)				
1973	93 (D / D)	Ford (R)				
1974	93 (D / D)	Ford (R)				
1975	94 (D / D)	Ford (R)				
1976	94 (D / D)	Ford (R)				
1977	95 (D / D)	Carter (D)	CNMs get independent reimbursement under CHAMPUS - first time CNM's recognized by name in federal legislation (Q, v8n2)			S1702 (Inouye) A bill to amend titles XVIII and XIX of the Social Security Act to provide for inclusion of services rendered by a nurse-midwife under the Medicare and Medicaid programs.
1978	95 (D / D)	Carter (D)				
1979	96 (D / D)	Carter (D)				HR3531 (Mikulski) A bill to

						<p>amend titles XVIII and XIX of the Social Security Act to provide for inclusion of services rendered by a certified nurse-midwife under the Medicare and Medicaid programs.</p> <p>S656 (Inouye) A bill to amend titles XVIII and XIX of the Social Security Act to provide for inclusion of services rendered by a certified nurse-midwife under the Medicare and Medicaid programs.</p>
1980	96 (D / D)	Carter (D)	<p>ACNM hires Sally Tom as first lobbyist (Q, v11n2)</p> <p>OBRA 1980 includes Mikulski/Inouye amendment to reimburse Midwives under Medicaid (Q, v11n2)</p>		CBO Report "Better Management and More Resources needed to Strengthen Federal Efforts to Improve	HR6349, HR6776 (Mikulski) A bill to amend titles XVIII and XIX of the Social Security Act to provide for inclusion of services rendered

					<p>Pregnancy Outcome” includes recommendation of greater use of nurse-midwife teams</p>	<p>by a certified nurse-midwife under the Medicare and Medicaid programs.</p> <p>HR4000 (Rangel) Medicare and Medicaid Amendments of 1980</p> <p>HR7765 (Giaino) Omnibus Reconciliation Act of 1980 *Included Medicaid amendment to cover services rendered by CNM *signed into law 12.5.80</p>
1981	97 (D / R)	Reagan (R)	Midwives form working group with HHS to promote greater use of nurse-midwives (Q, v11n2)			<p>HR4637 (Mikulski) A bill to amend title XVIII of the Social Security Act to provide for coverage under Medicare of services performed by a nurse-midwife.</p>

						S161 (Inouye) A bill to amend title XVIII of the Social Security Act to provide for coverage under Medicare of services performed by a nurse-midwife.
1982	97 (D / R)	Reagan (R)	GAO doing study of utilization and reimbursement of CNMs in federal health systems (Q, v13n1) Nurse-midwives win coverage under Blue Shield FEHBP (Q, v13n1)			
1983	98 (D / R)	Reagan (R)	Inouye and Mikulski introduce bills to provide for coverage under all FEHBP plans, and under Medicare (Q, v14n3)			HR 2652 (Mikulski) A bill to amend title XVIII of the Social Security Act to provide for coverage under Medicare of services performed by a nurse-midwife. S177 (Inouye) A

						bill to amend title XVIII of the Social Security Act to provide for coverage under Medicare of services performed by a nurse-midwife.
1984	98 (D / R)	Reagan (R)				
1985	99 (D / R)	Reagan (R)	<p>Midwives facing malpractice crisis – all carriers dropping CNMs due to low rates and low numbers despite low incidence of claims (Q, v16n4)</p> <p>75 midwives attend legislative leadership meeting in DC and lobby Congress about malpractice crisis (Q, v16n5)</p> <p>Energy and Commerce Committee holds hearing on malpractice crisis for midwives (Q, v16n5)</p> <p>Congress passes bill to give CNMs direct reimbursement</p>			S146 (Inouye) A bill to amend title XVIII of the Social Security Act to provide for Medicare coverage of services performed by a nurse-midwife.

			under FEHBP, President Reagan vetoes (Q, v16n7)			
1986	99 (D / R)	Reagan (R)	Carnegie Foundation issues landmark study calling for expansion of midwifery role (Q, v16n7) Congress passes Risk Retention Amendments of 1986 to make greater insurance options available (Q, v17n5)			
1987	100 (D / D)	Reagan (R)	ACNM lobbies for direct reimbursement under Medicare (Q,v18n2)			S124 (Inouye) A bill to amend title XVIII of the Social Security Act to provide that certified nurse-midwife services are covered under part B of Medicare. S167 (Inouye) A bill to amend chapter 89 of title 5, United States Code, to provide authority for the direct payment or reimbursement to nurse-midwives, nurse practitioners, and nurses, to

						<p>clarify certain provisions of such chapter with respect to coordination with State and local law, and for other purposes.</p> <p>HR2864 (Duncan) Medicare Amendments of 1987</p> <p>HR3545 (Gray) : Omnibus Budget Reconciliation Act of 1987 *included Medicare amendment to cover services rendered by CNM *signed into law 12.22.87</p>
1988	100 (D / D)	Reagan (R)	<p>Karen Fennell hired as Government Relations Coordinator (Q, v19n5)</p> <p>7.1.88 Medicare begins providing coverage of CNM services at 65% of applicable prevailing charge</p>	BOD establishes Advisory Panel on National Health Policy (APNHP) to develop federal policy agenda – 7 members, cross section of CNMs		<p>HR 5475 (Roybal) Nursing Shortage and Nurse Reimbursement Incentive Act of 1988 *direct reimbursement for</p>

			for the same service when performed by a physician (Q,v29n3)	from 6 regions (BOD ??88)		nursing services *based on fee schedule to be developed
1989	101 (D / D)	Bush (R)	HCFA issues guidelines for direct payment of CNMs : 65% of physician fee schedule and only includes maternity cycle (Q, v20n1)			OBRA1989 *changes physician payment from fee for service to relative value scale beginning 1992 *conforming amendment states CNMs will be paid 65% of MD fee schedule *PPRC must submit report to Congress on implications of RVS on non-MD providers
1990	101 (D / D)	Bush (R)	PPRC to submit report on implications of resource based relative value scale for non-physician providers currently paid by fee for service (Q, v21n1) ACNM begins to try and educate members about the importance of Medicare reimbursement (Q, v21n2) Lisa Paine meets with PPRC	APNHP makes 6 policy recommendations, BOD disbands APNHP, charges PEAC and Fennell to develop strategic plan to implement policy priorities (BOD Feb90) BOD sets 2 goals for changing federal	Teresa Marchese testifies before PPRC	

			<p>staff (Q, v21n4)</p> <p>Teresa Marchese testifies before PPRC about CNM payment (Q,v21n6)</p>	<p>health policy including CNM reimbursement (BOD ??90)</p> <p>BOD terminates contract with HPA (BOD July90)</p>		
1991	102 (D / D)	Bush (R)	<p>PPRC recommends CNM % differences be replaced with differential based on work (educational expenses), practice expenses and malpractice costs. ACNM opposes educational determination (Q, v22n4)</p> <p>ACNM participates in Hill briefing about PPRC recommendations (Q,v22n4)</p> <p>ACNM joins AP nursing coalition to seek higher federal payment (Q, v22n6)</p> <p>Inouye champions FY92 Defense Approps language to pay CNMs 100% under Champus (Q, v23n1)</p> <p>ACNM forms Washington Lobby Group to make</p>		"A Resource Guide for Giving Public Testimony"	<p>S2103 (Grassley) Primary Care Health Practitioner Incentive Act of 1991 introduced</p> <p>*97%</p> <p>* NPs, CNMs & CSs</p> <p>*HPSA bonus</p>

			regular Hill visits (Q,v23n2)			
1992	102 (D / D)	Bush (R)	<p>ACNM joins AP nursing groups to host 1/92 meeting “Nursing Reimbursement – How to get Paid for Your Services” (Q, v23n2)</p> <p>ACNM continues to educate members about importance of Medicare equity (Q,v23n2)</p> <p>National Office government affairs active in multiple issues including: *opposition to MCH Block Grant transfer *reversing DEA proposal that ties RX authority to MD *Overturning restrictions for AP nurses in Title X clinics (Q, v24n2)</p> <p>Medicaid bureau Director Christine Nye clarifies that states may expand CNM services beyond maternity cycle (Q, v24n2)</p>	<p>BOD directs KF to devote 8 hours / week to lobbying for Medicare & Medicaid scope of practice expansion (BOD Aug92)</p> <p>BOD rejected proposal to hire lobbying firm because cost prohibitive</p>	<p>“ACNM Legislative Manual 1992”</p>	<p>HR 4963(Towns) Primary Care Health Practitioner Incentive Act of 1992 introduced *97% *NPs, CNMs & CSs *HPSA bonus Companion bill to S2103</p> <p>HR 5825 (Richardson) To amend title XVIII of the Social Security Act to clarify coverage of certified nurse-midwife services performed outside the maternity cycle under the Medicare and Medicaid programs.</p> <p>S3274 (Bensten) Medicare and Medicaid Amendments Act of 1992 *to expand CNM Medicare payment</p>

						to outside the maternity cycle *passed as part of Tax bill, but vetoed by Bush
1993	103 (D / D)	Clinton (D) Proposed agenda of health reform	Deanne Williams CNM hired as first Director of Professional Services (Q, v24n1) ACNM issues position statement on health care reform (Q, v24n2) ACNM cosponsors nursing breakfast for new MOCs (Q, v24n3) As Clinton Health Reform efforts move forward, ANA takes the position that defines AP nurses as having a master's degree. ACNM reiterates its support for CNM educational pathways, and decides not to sign on to ANA health reform evaluation paper (Q, v24n6)	BOD charges KF with developing a Women's Health Care Agenda (BOD Feb93) BOD votes to endorse revised Clinton Health Reform plan introduced by Rep Gebhart and Senator Mitchell September 1993 (BOD Dec93)		HR 2386 (Townes) / S833 (Grassley) Primary Care Health Practitioner Incentive Act of 1993 introduced *97% *NPs, CNMs & CSs *HPSA bonus HHS Office of the IG report OEI-01-90-62070 *enhancing utilization of non-MD providers *Identified barriers to expansion of CNMs & NPs HR2264 OBRA1993 *extended Medicare and Medicaid payment for CNMs beyond maternity cycle *championed by

						Rep. Richardson, Senators Rockefeller and Moynihan
1994	103 (D / D)	Clinton (D)	ACNM holds first solo legislative conference "Health Care Reform, a Time for Action" – five day meeting had over 100 attendees (Q, v24n6; v25n3)	BOD establishes Legislative Leadership Award (BOD Feb94)	Lisa Summers testifies to PPRC	
1995	104 (R / R)	Clinton (D)	Internet and BBS help midwives to be more politically active (Q, v26n1) 2nd annual legislative conference "Health Care in Transition, Market and Legislative Initiatives" – five day meeting with 75 attendees (Q, v26n3) Members pledge \$10,000 at annual meeting to educate Managed Care about midwife practice (Q, v26n4) College begins educating members about importance of proper billing and coding practices (Q, v26n4) Fall Legislative Conference			HR 1750 (Townsend) / S864 (Grassley) Primary Care Health Practitioner Incentive Act of 1995 introduced *85% *NPs, & CSs ONLY

			<p>held with Service and Education Directors meetings (Q, v26n4)</p> <p>National Center for Health Statistics reports CNM attended births reach 188,370, 4.7% of all hospital births in 1993 (Q,v26n6)</p>			
1996	104 (R / R)	Clinton (D)	<p>ACNM develops first Web Page (Q, v27n2)</p> <p>ACNM launches automated practice locator 1-888-MIDWIFE (Q,v26n5)</p> <p>First CM program opens at SUNY Downstate</p> <p>National Center for Health Statistics reports CNM attended births reach 195,410 - 5.2% of all hospital births in 1994 (Q,v27n6)</p>	<p>BOD to convene 3 hours early in December to focus on women's health policy (BOD Sept96)</p> <p>BOD creates subgroup to develop priorities for action related to increasing ACNM presence in women's health policy arena (BOD Dec96)</p> <p>BOD sets goal of 97% reimbursement in the 105th Congress (BOD Dec96)</p>		
1997	105 (R / R)	Clinton (D)	<p>ACNM replicates Harvard study that developed the RBRVS used by Medicare – found only difference from</p>			<p>HR 893 (Townes) / S370 (Grassley) Primary Care Health Practitioner</p>

			<p>MDs was in malpractice costs, so will continue to seek 97% reimbursement (Q,v28n2)</p> <p>Private payers and Medicaid begin converting allowable payment schedules to variation of the RBRVS (Q,v28n2)</p> <p>ACNM holds Legislative Conference in March (Q,v28n2)</p> <p>California CNMs issue challenge for state that finds a sponsor for 97% legislation (Q,v28n4)</p> <p>ACNM and NANPRH co-host Hill briefing on “Policy Issues in Women’s Health – the Perspective from CNMs and NPs” (Q,v29n1)</p> <p>National Center for Health Statistics reports CNM attended births reach 216,768 – 5.5% of total US live births in 1995 (Q,v28n5)</p>			<p>Incentive Act of 1997 introduced *85% *NPs, & CSs ONLY Passes in BBA1997</p>
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1998	105 (R / R)	Clinton (D)	<p>ACNM holds legislative conference in February and awards 3 legislators (Q,v29n2)</p> <p>ACNM part of PARCA Alliance to support managed care reform (Q,v29n2)</p> <p>ACNM begins actively soliciting money to support legislative efforts (Q,v29n2)</p> <p>Rep Towns agrees to introduce CNM Medicare legislation – for political reasons ACNM agrees to 95% instead of 97% (Q, v29n3)</p> <p>Members donate \$13,000 – ACNM hires Roger Schwartz JD to assist writing the legislation, Muse and Assoc. actuarial firm to conduct cost analysis, and Washington Firm lobbying group to develop and implement lobbying strategy (Q,v29n4)</p> <p>KF testifies before Judiciary</p>	<p>BOD directs funds for an analysis of structure and tax status of potential PAC (BOD Feb/Mar98)</p> <p>BOD charges development of new Division of Women’s Health Policy and Leadership (BOD Nov98)</p>		<p>HR 4872 (Towns) Certified Nurse Midwife Medicare Services Act of 1998</p> <p>*95%</p> <p>*CNMs and CMs</p> <p>*Resident supervision</p> <p>*Birth Center payment</p>
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			<p>Committee against legislation to exempt private MDs from anti-trust laws (Q,v29n5)</p> <p>National Center for Health Statistics reports CNM attended births reach... (Q,v29n5)</p> <p>ACNM initiates "Adopt a Legislator" Program (Q,v30n1)</p>			
1999	106 (R / R)	Clinton (D)	<p>ACNM partners with AANP to host March Legislative Conference (first joint conference) (Q,v30n1)</p> <p>ACNM establishes "Capital Connection" on website to make legislative efforts easier (Q,v30n2)</p> <p>Legislative conference results in Upton (R-MI) agreeing to be lead cosponsor for HR2817 (Q,v30n3)</p> <p>ACNM creates "Adopt a Legislator Hall of Fame" to promote congressional</p>	<p>ACNM forms PAC, begins efforts to increase donations (BOD Feb99)</p> <p>Membership recommends to BOD that new Division of Women's Health Policy be established (BOD June99)</p> <p>ACNM explores technical assistance from HCFA with HR2817 (letter from B. Washington,</p>		<p>HR 2817 (Towns) Certified Nurse Midwife Medicare Services Act of 1999</p> <p>*95%</p> <p>*CNMs and CMs</p> <p>*Resident supervision</p> <p>*Birth Center payment</p>

			outreach (Q,v30n5)	HCFA Office of Legislation, undated1999)		
2000	106 (R / R)	Clinton (D)	<p>ACNM sponsors lobby day in March – 60 midwives make Hill visits promoting HR2817 and seeking Senate sponsors (Q, v31n2)</p> <p>ACNM begins promoting importance of PAC for greater political influence (Q,v31n2, v31n5)</p> <p>State chapters increase efforts to reach out to MOCs at home (Q, v31n2)</p> <p>ACNM adds services of The Federal Group (Patrick Cooney) as Legislative Consultant – begins efforts to “attach” Medicare bill to larger vehicle (Q, v31n3)</p> <p>ACNM publishes new handbook :”Getting Paid: Billing, Coding and Payment for Nurse-Midwifery Services” (Q, v31n5)</p> <p>ACNM pushes membership</p>	<p>BOD directs Program Committee, PEAC, PAC and National Office staff to work on large scale lobby effort during 2001 Annual Meeting in DC (BOD June00)</p>		<p>S2523 (Conrad) Promoting Access to Medicare Midwifery Services Act of 2000 *Towns companion bill</p>

			<p>to vote and get involved in political activity for 2000 election (Q, v31n6)</p> <p>Senate Finance introduces bill calling for study of appropriateness of payment for CNMs, NPs and PAs under Medicare which could slow down CNM efforts for 95% reimbursement (Q, v31n7)</p> <p>ACNM contracts with Membership Marketing Services to fund raise for PAC - members contribute \$98,000 (Q, v31n7)</p>			
2001	107 (R / E)	GW Bush (R) 9-11 terrorist attacks	<p>ACNM pushes members to dress professionally and participate in Lobby Day during annual meeting (Q, v32n2)</p> <p>Successful lobby day as 600 members storm Capital during Convention (Q, v32n4)</p> <p>HCFA becomes CMS, makes plans to issue National Provider Identifiers (NPIs) mandated under HIPPA to</p>			<p>HR 3602 (Towns) Certified Nurse Midwife Medicare Services Act of 2001 *95% *CNMs and CMs *Resident supervision *Birth Center payment</p>

			replace UPINs in 2002 (Q, v32n4)			
2002	107 (R / E)	GW Bush (R)	<p>ACNM begins to highlight importance of midwifery practices that focus on women with disabilities (Q, v33n2)</p> <p>ACNM makes legislative letter writing easy on website (Q, v33n3)</p> <p>Professional liability crisis big concern for OB/Gyns and midwives (Q, v33n5, v33n6)</p>	BOD approves <i>myMidwife</i> consumer group to be formed within ACNM		
2003	108 (R / R)	GW Bush (R) Rx Coverage efforts	<p>Professional liability crisis worsens, ACNM carrier announces it will no longer insure midwives after 2003 (Q, v34n2)</p> <p>ACNM contracts with new Insurance company for member malpractice coverage (Q, v34n3)</p> <p>National Center for Health Statistics report 305,606 CNM attended births in US – 10% of all vaginal births in</p>	<p>BOD directs KF to develop action plan for hiring lobbyists for Medicare effort (BOD June03)</p> <p>BOD approves legislative strategy to remove birth center provision from Medicare bill (BOD Mar03) BOD endorsed hiring of a CNM policy fellow to</p>		<p>HR 2980 (Towns) Medicare Payment Update for Certified Nurse-Midwives Act of 2003 *95% *CNMs and CMs *Resident supervision *Findings section *NO birth center piece</p>

			<p>2001 (Q, v34n6)</p> <p>Members pledge \$26,000 to hire CNM fellow to promote Medicare bill (Q, v34n6)</p> <p>Legislative strategy focuses on educating Republicans and convincing the Medicare Conference Committee to include HR2980 language in joint Medicare bill (Q,v34n6)</p> <p>Leadership makes effort to convince membership of their unique abilities to care for disabled women (Q,v34n7)</p> <p>ACNM promotes increased grassroots advocacy – advises persistence (Q,v34n7)</p> <p>Bush signs Medicare Modernization Act (Rx plan) into law which does not include CNM Medicare piece (Q,v35n1)</p>	<p>work on the Medicare effort , and paid for by chapter contributions (BOD June03)</p> <p>BOD approves PEAC to become a stand-alone committee (BOD June03)</p>		
2004	108 (R / R)	GW Bush (R)	ACNM lets Karen Fennell go, hires Cooney and Associates to implement policy	BOD charges PC and KateH to develop educational process	ACNM meets with CMS Medicare Management	S2492 (Conrad) Improving Access to Nurse-Midwife

			<p>initiatives (Q,v35n1)</p> <p>Midwives take leading role in Republican fight for malpractice reform (Q,v35n2)</p> <p>Cooney advises ACNM that PAC dollars go farther if used locally (Q,v35n7)</p> <p>PEAC becomes GAC (Q,v35n7)</p>	<p>for membership around endorsement of Congressional candidates (BOD Sept04)</p>	<p>Director H. Kuhn to discuss issues of concern. Follows with memo outlining background stats and history of CNMs and Medicare issues of concern (Memo to H. Kuhn, June04)</p>	<p>Care Act of 2004</p> <p>*Towns companion bill</p>
2005	109 (R / R)	<p>GW Bush (R)</p> <p>Hurricane Katrina</p>	<p>ACNM focuses on preparing members for lobby day during annual meeting (Q,v36n2, v36n3)</p> <p>Over 500 midwives met with over 300 MOCs to promote HR872 and S911 for 100% Medicare equity (Q,v36n4)</p> <p>ACOG opposes CNM bill asking congress to address Physician payment SGR fix before other provider bills (Q,v36n4)</p> <p>Members encouraged to follow up with legislators</p>	<p>Legislative sessions well attended and productive; Appointment making for Lobby Day was chaos (GAC report June05)</p> <p>ACNM responds to ACOG letter citing outstanding CNM</p>		<p>HR 872 (Towns) / S911 (Conrad) Improving Access to Nurse-Midwife Care Act of 2005</p> <p>*100%</p> <p>*CNMs and CMs</p> <p>*Resident supervision</p>

			<p>they met with during Lobby Day (Q,v36n5)</p> <p>LynnH flies to DC to meet with Grassley and Harkin. Grassley agrees to sign on to S911 (Q,v36n7)</p> <p>Twenty-three national nursing organizations endorsed CNM Medicare bill (Q,v37n1)</p> <p>Senator Conrad offers amendment in Senate Finance for CNM payment increase – pulled before all amendments voted down so as not to have a negative vote (Q,v37n1)</p>	<p>statistics “at least comparable to OBGyns” and CBO negligible cost estimate for CNM Medicare bill (KCCarr official correspondence June05)</p>		
2006	109 (R / R)	GW Bush (R)	<p>New monthly legislative publication begins with reports from federal and state and GAC committee (Advocate Jan06)</p> <p>ACNM plans Midwifery Advocacy Month in August (Q,V37n3)</p> <p>National Perinatal Association endorses</p>			

			<p>equitable Medicare reimbursement for CNMs thanks to efforts of CNM on their BOD (Advocate Apr06)</p> <p>BOD lets Deanne Williams go, names executive secretary temporary ED (Q,v37n5)</p> <p>ACNM meets with CMS to discuss differing CNM supervision standards under Medicare and Medicaid, and the supervision of medical residents by CNMs (Q,v37n5)</p> <p>Congress adjourns without fixing SGR problem for providers, ACNM had hoped to attach CNM Medicare reimbursement to that effort (Advocate Oct06)</p> <p>Congress passed SGR fix in lame duck period. ACNM attempted to have CNM Medicare reimbursement attached to bill, but was told bill would only include provisions expiring from previous year (Advocate</p>			
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			Dec06)			
2007	110 (D / E)	GW Bush (R)	<p>Midwives encouraged to reach out to new legislators and offer technical expertise (Advocate Jan07)</p> <p>Lorrie Kline Kaplan joins ACNM as new ED (Q,v38n2)</p> <p>ACOG endorses Midwife Medicare Bill (Q,v38n2)</p> <p>ACNM encourages members in 10 ways to influence Congress (Q,v38n2)</p> <p>GAC mobilizes midwives in all six regions to promote Equity legislation in hopes of having it included in SCHIP legislation (Q,v38n3)</p> <p>ACNM creates web page to promote National Midwifery Advocacy Month (Q,v38n3)</p> <p>Aggressive lobbying efforts add 11 new House cosponsors and 1 new Senate cosponsor (Advocate July07)</p>	<p>GAC recommends to BOD that 3 step action plan be initiated to increase legislative advocacy success:1) 10 member rapid response team, 2)advocacy academy and storm the hill event, 3)same as above but also open to all members (GAC report Aug07)</p>		<p>HR 864 (Townes) / S507 (Conrad) : Midwifery Care Access and Reimbursement Equity Act of 2007 *100% *CNMs and CMs *Resident supervision Included in House CHAMP Act</p> <p>HR3162 (?) Children's Health and Medicare Protection Act of 2007 *Midwife Medicare reimbursement equity provision included *Passed House 8.1.07</p>

			<p>CNM Medicare equity provision included in CHAMP Act which passes House (Q,v38n4)</p> <p>House passes CHAMP Act, Senate has only passed an SCHIP reauthorization bill – ACNM advocating for the House provision in Conference (Advocate Aug07)</p> <p>SCHIP reauthorization bill passes Congress, Bush will veto, midwife Medicare equity provision not included (Advocate Oct07)</p> <p>Conference negotiators discussed including CNM Medicare piece at 85% rather than 100% - ACNM did not support this (Advocate Jan08)</p> <p>Medicare update legislation passed as stripped down bill, midwife piece not included (Q,v39n1)</p>			
2008	110 (D / E)	GW Bush (R)	Senators Hillary Clinton and Blanche Lincoln sign as cosponsors for bill			

			<p>(Q,v39n1)</p> <p>ACNM members attend political function for Max Baucus in MT (Advocate April08)</p> <p>Senate support for bill increases to 21 senators, ACNM gearing up for possible health reform effort in 2009 (Q,v39n2)</p> <p>ACNM plans grassroots effort to have CNM Medicare equity piece included in Senate Finance Medicare package necessary to forestall 10.6% SGR cuts (Advocate June08)</p> <p>Senate dysfunction prevents passage of even stripped down Medicare bill – CNM piece will not make it in this year despite Senator Conrad’s support (Advocate July08)</p> <p>ACNM encourages members to get educated about candidates and involved in</p>	<p>GAC recommends to BOD new process for developing yearly policy agenda (GAC BOD item April08)</p> <p>GAC members experiencing burnout after full court press for over a year, and difficulty engaging other members (GAC report May08)</p> <p>Concerns that Grassley may push for 85% payment if CNM piece is brought up for inclusion in Senate Medicare package (GAC report May08)</p>		
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			<p>election (Q,v39n3)</p> <p>ACNM educates members about debt, deficit, and realities of compromise legislation (Q,v39n4)</p>			
2009	111 D/D	Obama (D) Health Reform Agenda	<p>ACNM Presidency changes midterm – Kitty Ernst retires and VP Avery takes over (Q, v40n1)</p> <p>ACNM sets aggressive policy agenda in response to elections leaving Dems controlling House, Senate and Presidency (Q,v40n1)</p> <p>ACNM working to promote its health reform agenda which includes increased Medicare reimbursement (Q,v40n2)</p> <p>CNM Medicare equity provision is included in both House and Senate health reform bills. CMs are not included in either legislation (Q, v40n4)</p>			<p>HR1101 (Towns) / S662 (Conrad) Midwifery Care Access and Reimbursement Equity Act of 2009 *100% *CNMs and CMs *NO Resident piece</p> <p>HR3590 (Rangel) Patient Protection and Affordable Care Act *includes 100% CNM reimbursement *CMs not included *passes House 10.8.09 *passes Senate with amendments</p>

						12.24.09 S??? (Reid) *includes 100% CNM reimbursement *CMs not included
2010	111 D/D	Obama (D)	At Last – Equitable reimbursement is law. The President signed PPACA into law and midwives are scheduled to receive 100% reimbursement under Medicare beginning 1.1.11 (Q,v41n2) ACNM works to explain to membership why CMs were not included in the bill, applauds the fact that birth centers receive Medicaid reimbursement in the new law (Q,v41n2)			HR3590 (Rangel) Patient Protection and Affordable Care Act *includes 100% CNM reimbursement *CMs not included *Passes House with Senate Amendments 3.21.10 *signed into law 3.23.10

APPENDIX E

Nurse Practitioner Medicare Equity Documents & Timeline

Year	Congress (H / S)	President	ANA Capital Updates	ACNM Quickening / Internal Documents	Congressional Bill Summaries / Federal Publications
1965	89 (D / D)	Johnson (D)			HR1/S1 Social Security Amendments of 1965 – become Public Law 89-97 in July 1965, Medicare and Medicaid are established
1966	89 (D / D)	Johnson (D)			
1967	90 (D / D)	Johnson (D)			
1968	90 (D / D)	Johnson (D)			
1969	91 (D / D)	Nixon (R)			
1970	91 (D / D)	Nixon (R)			
1971	92 (D / D)	Nixon (R)			
1972	92	Nixon			

	(D / D)	(R)			
1973	93 (D / D)	Ford (R)			
1974	93 (D / D)	Ford (R)			S3644 (Inouye) A bill to amend the Social Security Act to provide for inclusion of the services of licensed (registered) nurse practitioners under Medicare and Medicaid
1975	94 (D / D)	Ford (R)			
1976	94 (D / D)	Ford (R)			
1977	95 (D / D)	Carter (D)		CNMs get independent reimbursement under CHAMPUS – first time CNM’s recognized by name in federal legislation (Q, v8n2)	HR5266 (Roybal) A bill to amend titles XVIII and XIX of the Social Security Act to include services of licensed (registered) nurses, physician extenders, and nurse practitioners among the services for which payment may be made under the Medicare and Medicaid programs.
1978	95 (D / D)	Carter (D)			
1979	96 (D / D)	Carter (D)			HR1140 (Roybal) A bill to amend titles XVIII and XIX of the Social Security Act to

					<p>include services of licensed (registered) nurses, physician extenders, and nurse practitioners among the services for which payment may be made under the Medicare and Medicaid programs.</p> <p>S1239 (Inouye) A bill to amend title 5, United States Code, to provide for access to qualified professional psychiatric nurse practitioners without prior referral in the Federal employee health benefits program.</p>
1980	96 (D / D)	Carter (D)		OBRA 1980 includes Mikulski/Inouye amendment to reimburse Midwives under Medicaid (Q, v11n2)	<p>S2644 (Inouye) A bill to amend the Social Security Act to provide for the direct reimbursement of qualified gerontological nurse practitioners under Medicare and Medicaid.</p> <p>S2645 (Inouye) A bill to amend title 5, United States Code, to provide for access to qualified professional gerontological nurse practitioners without prior</p>

					referral in the Federal employee health benefits program.
1981	97 (D / R)	Reagan (R)			<p>HR597 (Roybal) A bill to amend titles XVIII and XIX of the Social Security Act to include services of licensed (registered) nurses, physician extenders, and nurse practitioners among the services for which payment may be made under the Medicare and Medicaid programs.</p> <p>S103 (Inouye) A bill to amend title 5 of the United States Code to provide payments under Government health plans for services of nurses not performed in connection with a physician.</p> <p>S110 (Inouye) A bill to amend titles XVIII and XIX of the Social Security Act to provide that gerontological nurse practitioner services shall be covered under part B of Medicare and shall be required service under Medicaid.</p>

1982	97 (D / R)	Reagan (R)		Nurse-midwives win coverage under Blue Shield FEHBP (Q, v13n1)	
1983	98 (D / R)	Reagan (R)		Inouye and Mikulski introduce bills to provide for coverage under all FEHBP plans, and under Medicare for CNMs (Q, v14n3)	<p>S172 (Inouye) A bill to amend title 5 of the United States Code to provide payments under Government health plans for services of nurses not performed in connection with a physician.</p> <p>S174 (Inouye) A bill to amend titles XVIII and XIX of the Social Security Act to provide that pediatric nurse practitioner services shall be covered under part B of Medicare and shall be a required service under Medicaid.</p> <p>S176 (Inouye) A bill to amend titles XVIII and XIX of the Social Security Act to provide that gerontological nurse practitioner services shall be covered under part B of Medicare and shall be a required service under Medicaid.</p>

1984	98 (D / R)	Reagan ®	Senators Hatfield and Inouye send letter to Congressional Office of Technology Assessment (OTA) requesting studies on status of NP reimbursement (CU, v2n7)		
1985	99 (D / R)	Reagan (R)	President vetoes bill to give direct reimbursement to NPs under FEHBP (CU, v4n1)	Congress passes bill to give CNMs direct reimbursement under FEHBP, President Reagan vetoes (Q, v16n7)	<p>HR3384 (Oakar) Federal Employees Benefits Improvement Act of 1985 *establishes contracting authority for nurses, certified nurse-midwives, and clinical social workers *passed but vetoed by President</p> <p>S74 (Inouye) A bill to amend titles XVIII and XIX of the Social Security Act to provide that the services of a pediatric nurse practitioner or pediatric clinical nurse specialist shall be covered under part B of Medicare and shall be a required service under Medicaid.</p> <p>S76 (Inouye) Amends titles XVIII and XIX (Medicare and Medicaid) of the Social Security Act to provide coverage for psychiatric clinical nurse specialist or</p>

					<p>psychiatric nurse practitioner services under Medicaid and part B (Supplementary Medical Insurance) of Medicare.</p> <p>S77 (Inouye) A bill to amend titles XVIII and XIX of the Social Security Act to provide that the services of a gerontological nurse practitioner or gerontological clinical nurse specialist shall be covered under part B of Medicare and shall be a required service under Medicaid.</p> <p>S136 (Inouye) A bill to amend title 5 of the United States Code to provide payments under Government health plans for services of nurses not performed in connection with a physician.</p>
1986	99 (D / R)	Reagan (R)	<p>OBRA86 gives direct Medicare reimbursement to nurse anesthetists at 80% if the fee schedule (CU, v4n21)</p> <p>Physician Payment Review Commission begins to explore</p>		<p>HR 4825 (Oakar) A bill to amend chapter 89 of title 5, United States Code, to provide authority for the direct payment or reimbursement of certain additional types of health</p>

			<p>non-MD provider impact on costs and access (CU, v4n23)</p> <p>OTA issues report on quality and cost effectiveness of NPs, PAs and CNMs (CU, v5n1)</p>		<p>care professionals. *direct payment for NPs, RNs and CNMs under FEHBP</p>
1987	100 (D / D)	Reagan (R)	<p>Reconciliation bill (PL 100-203) contains provision to allow HHS to establish 4 demonstration projects for community nursing organizations. This would be the first time Medicare paid services would not fall under direct supervision of a physician (CU, v5n24)</p>		<p>HR382 (Oakar) Federal Employees Health Care Freedom-of-Choice Act of 1987 *direct payment for NPs, RNs and CNMs under FEHBP</p> <p>S94 (Inouye) A bill to amend titles XVIII and XIX of the Social Security Act to provide that pediatric nurse practitioner or pediatric clinical nurse specialist services are covered under part B of Medicare and are a mandatory benefit under Medicaid.</p> <p>S96 (Inouye) A bill to amend titles XVIII and XIX of the Social Security Act to provide that psychiatric nurse practitioner or psychiatric clinical nurse specialist services are covered under part B of Medicare and are a mandatory benefit under</p>

					<p>Medicaid, and for other purposes.</p> <p>S126 (Inouye) A bill to amend titles XVIII and XIX of the Social Security Act to provide that gerontological nurse practitioner or gerontological clinical nurse specialist services are covered under part B of Medicare and are mandatory benefit under Medicaid, and for other purposes.</p> <p>S167 (Inouye) A bill to amend chapter 89 of title 5, United States Code, to provide authority for the direct payment or reimbursement to nurse-midwives, nurse practitioners, and nurses *direct reimbursement under FEHBP</p>
1988	100 (D / D)	Reagan (R)	House holds hearing on Roybal bill to provide direct Medicare and Medicaid reimbursement to NP, CNSs, NAs and CNMs (CU, v6n19)	7.1.88 Medicare begins providing coverage of CNM services at 65% of applicable prevailing charge for the same service when performed by a physician (Q,v29n3)	HR5475 (Roybal) Nursing Shortage and Nurse Reimbursement Incentive Act of 1988 *direct reimbursement under Medicare for nursing services *based on fee schedule to be

					<p>developed</p> <p>HR5492 (Roybal) National Rural Health Care Act *direct reimbursement under Medicare for NPs and CNSs *based on fee schedule to be developed</p>
1989	101 (D / D)	Bush (R)	<p>CHAMPUS releases report finding the impact of reimbursing NPs negligible (CU, v7n9)</p> <p>OBRA89 mandates PPRC study of payment to non-MD providers (CU, v7n24)</p>	<p>HCFA issues guidelines for direct payment of CNMs : 65% of physician fee schedule and only includes maternity cycle (Q, v20n1)</p>	<p>HR211 (Oakar) Federal Employees Health Care Freedom-of-Choice Act *direct payment for NPs, RNs and CNMs under FEHBP</p> <p>HR1140 (Roybal) Nursing Shortage and Nurse Reimbursement Incentive Act of 1989 *direct reimbursement under Medicare for NPs, CNSs and CNMs * study of obstacles nurses face in receiving direct reimbursement.</p> <p>HR2673 (Markey) To amend title XVIII of the Social Security Act to provide coverage of nurse practitioner services under the Medicare program.</p> <p>S112 (Inouye) A bill to</p>

					<p>amend chapter 89 of title 5, United States Code, to provide authority for the direct payment or reimbursement to nurse-midwives and nurse practitioners *direct reimbursement under FEHBP</p> <p>S115 (Inouye) A bill to amend titles XVIII and XIX of the Social Security Act to provide that nurse practitioner or clinical nurse specialist services are covered under part B of Medicare and are a mandatory benefit under Medicaid.</p> <p>S119 (Inouye) A bill to amend titles XVIII and XIX of Social Security Act to provide that pediatric nurse practitioner or pediatric clinical nurse specialist services are covered under part B of Medicare and are a mandatory benefit under Medicaid.</p>
1990	101	Bush	HCFA releases regulations for	PPRC to submit report on	H.R.2989 (Roybal) Treasury,

	(D / D)	(R)	<p>payment of NP services delivered to residents of Medicare and Medicaid certified nursing facilities (CU, v8n8)</p> <p>PPRC conducting study on payments to nurse practitioners and implication for Medicare fee schedule (CU, v8n19)</p> <p>Treasury Approps bill contains provision for direct payment of NPs, CNSs and CNMs under FEHBP (CU, v8n22)</p> <p>OBRA90 grants direct Medicare reimbursement to NPs and CNSs in rural areas (CU, v8n23)</p>	<p>implications of resource based relative value scale for non-physician providers currently paid by fee for service (Q, v21n1)</p>	<p>Postal Service and General Government Appropriations Act, 1990</p> <p>*direct reimbursement for NPs, CNSs and CNMs under FEHBP</p>
1991	102 (D / D)	Bush (R)	<p>PPRC recommends elimination of “incident to” payment and RBRVS differential payment for non-MDs be determined by differences in work, practice expense and liability insurance (CU, v9n5)</p> <p>ANA and other Nonphysician Practitioner Coalition</p>	<p>PPRC recommends non-MD provider % differences be replaced with differential based on work (educational expenses), practice expenses and malpractice costs. ACNM opposes educational determination (Q, v22n4)</p> <p>ACNM participates in Hill briefing about PPRC</p>	<p>S161 (Inouye) A bill to amend titles XVIII and XIX of the Social Security Act to provide that nurse practitioner or clinical nurse specialist services are covered under part B of Medicare and are a mandatory benefit under Medicaid.</p>

			<p>members host Congressional briefing on PPRC recommendations (CU, v9n14)</p> <p>Grassley and Moynihan introduce bill to provide direct reimbursement to NPs, CNSs and CNMs at 97% of fee schedule (CU, v10n1)</p>	<p>recommendations (Q,v22n4)</p> <p>ACNM joins AP nursing coalition to seek higher federal payment (Q, v22n6)</p>	<p>S2103 (Grassley) Primary Care Health Practitioner Incentive Act of 1991 introduced</p> <p>*97%</p> <p>* NPs, CNMs & CSs</p> <p>*HPSA bonus</p> <p>S1842 (Daschle) A bill to amend title XIX of the Social Security Act to provide for Medicaid coverage of all certified nurse practitioners and clinical nurse specialists services.</p>
1992	102 (D / D)	Bush (R)	<p>Richardson introduces bill to provide direct Medicaid reimbursement to NPs and CNSs (CU, v10n5)</p> <p>Towns introduces bill to provide direct Medicare reimbursement to NPs, CNS, and CNMs at 97% if fee schedule (CU, v10n8)</p> <p>Senate approves Medicare and Medicaid Amendments of 1992 with provisions to give direct reimbursement of NP, CNSs and PAs at 85% of MD fee schedule – House doesn't</p>	<p>ACNM joins AP nursing groups to host 1/92 meeting “Nursing Reimbursement – How to get Paid for Your Services” (Q, v23n2)</p>	<p>HR4311 (Richardson) To amend title XIX of the Social Security Act to provide for mandatory coverage of services furnished by nurse practitioners and clinical nurse practitioners under State Medicaid plans.</p> <p>HR 4963(Towns) Primary Care Health Practitioner Incentive Act of 1992 introduced</p> <p>*97%</p> <p>* NPs, CNMs & CSs</p> <p>*HPSA bonus</p> <p>Companion bill to S2103</p>

			pass (CU, v10n19)		
			Daschle introduces Senate companion bill to provide direct Medicaid payment to NPs and CNSs (CU, v9n21)		
1993	103 (D / D)	Clinton (D) Proposed agenda of health reform	<p>ANA officials and state nurses have 2 hour meeting with Hillary Clinton to discuss nursing issues in health reform (CU, v11n5)</p> <p>Daschle introduces bill to provide direct Medicaid payment to NPs and CNSs (CU, v11n5)</p> <p>Richardson introduces House companion to Daschle direct Medicaid reimbursement bill (CU, v11n7)</p> <p>Grassley and Conrad introduce bill to provide direct Medicare reimbursement at 97% of fee schedule to NPs, CNSs & CNMs (CU, v11n9)</p> <p>Towns introduces companion bill to provide direct Medicare reimbursement at 97% of fee schedule to NPs, CNSs & CNMs (CU, v11n12)</p>	<p>ACNM cosponsors nursing breakfast for new MOCs (Q, v24n3)</p> <p>As Clinton Health Reform efforts move forward, ANA takes the position that defines AP nurses as having a master's degree. ACNM reiterates its support for CNM educational pathways, and decides not to sign on to ANA health reform evaluation paper (Q, v24n6)</p>	<p>HR1683 (Richardson) To amend title XIX of the Social Security Act to provide for mandatory coverage of services furnished by nurse practitioners and clinical nurse specialists under State Medicaid plans.</p> <p>HR 2386 (Towns) / S833 (Grassley) Primary Care Health Practitioner Incentive Act of 1993 introduced *97% *NPs, CNMs & CSs *HPSA bonus</p> <p>S466 (Daschle) A bill to amend title XIX of the Social Security Act to provide for Medicaid coverage of all certified nurse practitioners and clinical nurse specialists services.</p> <p>HHS Office of the IG report OEI-01-90-62070</p>

			HCFA clarifies “incident to” rules that MD must be on site and provide both initial and continuing visits to patient (CU, v11n15)		*enhancing utilization of non-MD providers *Identified barriers to expansion of CNMs & NPs
1994	103 (D / D)	Clinton (D)	Clinton Health Reform agenda dies in Congress due to Republican opposition (CU, v12n19) Midterm elections give Republicans control of both House and Senate (CU, v12n22)		
1995	104 (R / R)	Clinton (D)	Richardson introduces bill to provide direct Medicaid reimbursement to NPs and CNSs (CU, v13n7) Grassley and Conrad introduce bill to provide direct Medicare reimbursement at 85% of fee schedule to NPs and CNSs (CU, v13n11) OBRA95 includes provision for direct reimbursement of NP under Medicare but is vetoed by President (CU, v14n2)		HR1339 (Richardson) To amend title XIX of the Social Security Act to provide for mandatory coverage of services furnished by nurse practitioners and clinical nurse specialists under State Medicaid plans. HR 1750 (Townes) / S864 (Grassley) Primary Care Health Practitioner Incentive Act of 1995 introduced *85% *NPs, & CSs ONLY S972 (Daschle) A bill to

					amend title XIX of the Social Security Act to provide for Medicaid coverage of all certified nurse practitioners and clinical nurse specialists services.
1996	104 (R / R)	Clinton (D)	Clinton includes provision for direct Medicare reimbursement for NPs and CNSs in FY97 budget (CU, v14n2)		
1997	105 (R / R)	Clinton (D)	Richardson introduces bill to provide direct Medicaid reimbursement to NPs and CNSs (CU, v15n1) Grassley and Conrad introduce bill to provide direct Medicare reimbursement at 85% of fee schedule to NPs and CNSs. Towns and Johnson introduce House companion bill (CU, v15n3) Clinton includes provision for direct Medicare reimbursement for NPs and CNSs in FY98 budget (CU, v15n9) ANA mobilizes N-STAT grassroots effort and works		HR258 (Richardson) To amend title XIX of the Social Security Act to provide for mandatory coverage of services furnished by nurse practitioners and clinical nurse specialists under State Medicaid plans. HR 893 (Towns) / S370 (Grassley) Primary Care Health Practitioner Incentive Act of 1997 introduced *85% *NPs, & CSs ONLY Passes in BBA1997 HR1352 (Olver) To amend title XIX of the Social Security Act to provide for mandatory coverage of services

			<p>with Medicare bill sponsors to get bill included in budget reconciliation bill (CU, v15n9)</p> <p>Ways and Means approves Medicare package with NP/CNS 85% payment included (CU, v15n10)</p> <p>BBA97 passes with NP/CNM Medicare reimbursement provision included (CU, v15n13)</p> <p>Passage of NP/CNS reimbursement is culmination of almost 8 years of work by ANA (CU, v15n15)</p> <p>ANA meets with HCFA to discuss implementation of reimbursement for NPs/CNSs (CU, v15n19)</p>		<p>furnished by nurse practitioners and clinical nurse specialists under State Medicaid plans.</p> <p>HR2105 (Kasich) Balanced Budget Act of 1997 *includes language from HR893/S370 *signed into law 8.5.97</p> <p>S1326 (Daschle) A bill to amend title XIX of the Social Security Act to provide for Medicaid coverage of all certified nurse practitioners and clinical nurse specialists services.</p>
1998	105 (R / R)	Clinton (D)			
1999	106 (R / R)	Clinton (D)			
2000	106 (R / R)	Clinton (D)			
2001	107 (R / E)	GW Bush (R)			

		9-11 terrorist attacks			
2002	107 (R / E)	GW Bush (R)			
2003	108 (R / R)	GW Bush (R) Rx Coverage efforts			
2004	108 (R / R)	GW Bush (R)			
2005	109 (R / R)	GW Bush (R) Hurricane Katrina			
2006	109 (R / R)	GW Bush (R)			
2007	110 (D / E)	GW Bush (R)			
2008	110 (D / E)	GW Bush (R)			
2009	111 D/D	Obama (D) Health Reform			

		Agenda			
2010	111 D/D	Obama (D)			

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CURRICULUM VITAE

Debbie Jessup graduated from Ursuline Academy in New Orleans, Louisiana, in 1971. She received her Bachelor of Science in Biology from Newcomb College of Tulane University in 1975, and her Master of Science in Nursing from Pace University in 1978. In 1981 Debbie received the joint degrees of Master of Science in Nurse-Midwifery from Columbia University and Master of Arts in Health Education from Teachers College of Columbia University.

Deb Jessup has over 30 years experience in midwifery, women's health and health policy. In her early career she worked as a childbirth educator, a labor and delivery nurse, and a nurse-midwife. Her midwifery experiences included private, community health center and HMO practices, and incorporated hospital, home, and birth-center settings. Deb established the first midwifery practice in Billings, Montana in 1982, and the first home birth practice in that city in 1984.

Throughout her career Deb has been significantly involved in women's health and midwifery policy activities, including being the Virginia Chapter American College of Nurse-Midwives (ACNM) Chair and Legislative Chair during the passage of state prescriptive authority for nurse-practitioners; serving on the ACNM Board of Directors from 1996 – 2000; and developing and chairing the ACNM Division of Health Policy from 2000 – 2005. She completed the HRSA Bureau of Health Professions Primary Care Policy Fellowship Program in 2000, and the Women's Education and Research Institute (WREI) Congressional Fellowship Program in 2005. Since that time she has been employed as a Health Legislative Specialist in the office of Congresswoman Lucille Roybal-Allard. In that position, she has been actively engaged in health appropriations work as well as helping the Congresswoman to develop and pass several pieces of health legislation.

Debbie is a Fellow of the American College of Nurse-Midwives.